# Albany Eye Care

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## CONFIDENTIAL HEALTH HISTORY

PATIENT'S NAME _____ **Today's Date** ____/____/____

*Please check "YES" or "NO" to indicate if you have had any of the following medical conditions.*

| | YES | NO |
|---|---|---|
| **VISION** | | |
| Blindness | ☐ | ☐ |
| Cataracts | ☐ | ☐ |
| Dry Eyes | ☐ | ☐ |
| Glaucoma | ☐ | ☐ |
| Macular Degeneration | ☐ | ☐ |
| Migraines | ☐ | ☐ |
| Retinal Disease | ☐ | ☐ |
| **GENERAL / CONSTITUTIONAL** | | |
| (Fever, Weight loss, Fatigue) | ☐ | ☐ |
| **EARS, NOSE, THROAT** | | |
| (Sinus, Ear Infection, Chronic Cough, | ☐ | ☐ |
| Hearing Loss, Dry Mouth) | ☐ | ☐ |
| **CARDIO/ VASCULAR** | | |
| Heart Disease | ☐ | ☐ |
| Heart Surgery | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ |
| Pacemaker/ Defibrillator | ☐ | ☐ |
| **RESPIRATORY** | | |
| (Asthma, Emphysema, COPD, | | |
| Lung Disease, SOB, TB) | ☐ | ☐ |
| **GASTRONINTESTINAL** | | |
| (Stomach, Ulcers, Intestinal) | ☐ | ☐ |
| **GENITOURINARY** | | |
| (Kidney, Bladder, Genital, Female) | ☐ | ☐ |
| **NEUROLOGICAL** | | |
| Headaches | ☐ | ☐ |
| (Numbness, Stroke, Seizure, | ☐ | ☐ |
| Epilepsy) | | |
| **MUSCULOSKELETAL** | | |
| (Artificial joint, pain/stiffness, Arthritis) | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| **SKIN** | | |
| (Rash, Lesions, Shingles) | ☐ | ☐ |
| **HEMATOLOGIC / LYMPHATIC** | | |
| (Bleeding, Clotting, Anemia, High Cholesterol) | ☐ | ☐ |
| **IMMUNOLOGICAL** | | |
| Lupus | ☐ | ☐ |
| Sjogrens | ☐ | ☐ |
| Hepatitis (Type _____) | ☐ | ☐ |
| HIV / AIDS | ☐ | ☐ |
| **PSYCHIATRIC** | | |
| (Anxiety, Depression, Insomnia) | ☐ | ☐ |
| **ENDOCRINE** | | |
| Thyroid | ☐ | ☐ |
| Diabetes- Diet Controlled | ☐ | ☐ |
| Diabetes- Oral Medication | ☐ | ☐ |
| Diabetes- Insulin | ☐ | ☐ |
| When first diagnosed _____ | | |
| **CANCER** | | |
| (Site _____) | ☐ | ☐ |
| Diagnosis Date _____ | | |
| **FAMILY HISTORY** | | |
| Blindness | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| Cataracts | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Glaucoma | ☐ | ☐ |
| Heart Disease | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ |
| Macular Degeneration | ☐ | ☐ |
| Retinal Disease | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Thyroid | ☐ | ☐ |

| **MEDICATIONS** | YES | NO |
|---|---|---|
| *Do you currently take any medication?* | ☐ | ☐ |

Please list, including eye drops…

_____

_____

_____

_____

_____

| **ALLERGIES** | YES | NO |
|---|---|---|
| *Do you have any food or drug allergies?* | ☐ | ☐ |

Please list allergy and type of reaction…

_____

_____

_____

_____

_____

PLASE LIST ANY OTHER MEDICAL PROBLEMS, HOSPITALIZATIONS, AND SURGERIES (INCLUDE REASON AND YEAR)….

_____

_____

_____

_____

_____

**SOCIAL HISTORY**

| | YES | NO | |
|---|---|---|---|
| Do you drink alcohol? | ☐ | ☐ | If yes, how often? _____ |
| Do you use tobacco? | ☐ | ☐ | If yes, how often? _____ How long?_____ QUIT ____ |
| Are you pregnant? | ☐ | ☐ | If yes, what trimester? ☐1st ☐2nd ☐3rd |
| Do you have children? | ☐ | ☐ | If yes, how many? _____ |

**Have you taken or are you currently taking any of the following?**

| | | | |
|---|---|---|---|
| Cortisone / Steroids | ☐ | ☐ | If yes, how often? _____ |
| Tranquillizers | ☐ | ☐ | If yes, how often? _____ |
| Sedatives | ☐ | ☐ | If yes, how often? _____ |
| Street Drugs | ☐ | ☐ | If yes, how often? _____ |
| Cocaine / Crack | ☐ | ☐ | If yes, how often? _____ |
| Marijuana | ☐ | ☐ | If yes, how often? _____ |

**VISION HISTORY / COMPLAINTS**

| | YES | NO | |
|---|---|---|---|
| Do you drive? | ☐ | ☐ | |
| Do you have visual difficulty when driving? | ☐ | ☐ | |
| Do you have problems with night vision? | ☐ | ☐ | |
| Do you have trouble when reading or doing close work? | ☐ | ☐ | |
| Do you currently wear contact lenses? | ☐ | ☐ | Age of Current Rx _____ |
| Do you currently wear glasses? | ☐ | ☐ | Age of Current Rx _____ |

Have you ever had any eye injuries / surgeries? _____

When was your last vision examination? _____

**My signature certifies that the CONFIDENTIAL HEALTH HISTORY is complete and accurate to the best of my knowledge and if in fact fraudulent, may place me at significant medical risk.**

_____ _____

Date Patient Signature/Legal Guardian or Representative

**FOR OFFICE USE ONLY:**

REVIEW DATE _____ BY _____ REVIEW DATE _____ BY _____

REVIEW DATE _____ BY _____ REVIEW DATE _____ BY _____

REVIEW DATE _____ BY _____ REVIEW DATE _____ BY _____