

Eye Care Center - Patient Health History Form

1965 11th Ave. E. – Suite 101, Maplewood, MN 55109 - Phone: 651-777-3555
1202 East More Lake Dr., Fridley, MN 55432 – Phone: 763-574-0075

Patient Name: _____ Date of Birth: _____ Date: _____

Please indicate if you have medical conditions involving the following body systems and give a brief description.

- | | Yes | No | | _____ |
|----|--------------------------|--------------------------|--------------------------------|-------|
| 1 | <input type="checkbox"/> | <input type="checkbox"/> | Ears/Nose/Throat/Mouth Disease | _____ |
| 2 | <input type="checkbox"/> | <input type="checkbox"/> | Heart Conditions | _____ |
| 3 | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | _____ |
| 4 | <input type="checkbox"/> | <input type="checkbox"/> | Blood Disorders | _____ |
| 5 | <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol | _____ |
| 6 | <input type="checkbox"/> | <input type="checkbox"/> | Urinary or Kidney Disease | _____ |
| 7 | <input type="checkbox"/> | <input type="checkbox"/> | Muscle or Joint Conditions | _____ |
| 8 | <input type="checkbox"/> | <input type="checkbox"/> | Skin Conditions | _____ |
| 9 | <input type="checkbox"/> | <input type="checkbox"/> | Stroke/Neurological Disease | _____ |
| 10 | <input type="checkbox"/> | <input type="checkbox"/> | Migraine Syndrome | _____ |
| 11 | <input type="checkbox"/> | <input type="checkbox"/> | Mental Health Conditions | _____ |
| 12 | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Imbalance/Disease | _____ |
| 13 | <input type="checkbox"/> | <input type="checkbox"/> | Seasonal Allergies | _____ |
| 14 | <input type="checkbox"/> | <input type="checkbox"/> | Immune system conditions | _____ |
| 15 | <input type="checkbox"/> | <input type="checkbox"/> | Asthma or Lung condition | _____ |
| 16 | <input type="checkbox"/> | <input type="checkbox"/> | Stomach/Intestinal Conditions | _____ |
| 17 | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | _____ |
| 19 | <input type="checkbox"/> | <input type="checkbox"/> | Other | _____ |

Indicate if you or any of your parents, brothers, or sisters has had the following conditions and briefly describe.

- | | | | | |
|----|--------------------------|--------------------------|----------------------------------|-------|
| 20 | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | _____ |
| 21 | <input type="checkbox"/> | <input type="checkbox"/> | Macular Degeneration | _____ |
| 22 | <input type="checkbox"/> | <input type="checkbox"/> | Eye Surgery (Not inc. Cataracts) | _____ |
| 23 | <input type="checkbox"/> | <input type="checkbox"/> | Other Eye Disease | _____ |

Do you smoke? Yes No

Do you use alcohol Yes No

Medications: Please list all medications you currently take, including any over the counter meds.

Medication Allergies: Please list all medications that you have allergies to.

Who is your Primary Care Physician? Please include clinic name, location and phone number.
