CARGILL EYECARE: PATIENT HEALTH HISTORY

Name: _____ Age: _____ Exam Date: _____

HISTORY: Ocular and Systemic

YOUR Medical History: (Surgeries, Diseases)				
Your **"FAMILY"** History: Is there a family member or blood relative with any of these conditions? Please note them.	**C**ataracts ( ) **G**laucoma ( ) **M**ac Degen ( ) **R**et.Detach ( ) **H**bp ( ) **H**igh Chol ( ) **D**iabetes ( ) **T**hyroid ( ) **O**ther ( )			***Record Who? F, M, B, S, GF, GM***
Social History	Alcohol: No ( ) Yes ( ) # _____ Per Week Other Substances ( ) Smoking: Never ( ) Former ( ) Current ( ) Smoking Cessation Discussed With Patient ( )			
Patient Initials and Date	**#1** Initl. [ ] Date:	**#2** Initl. [ ] Date:	**#3** Initl. [ ] Date:	**#4** Initl. [ ] Date:

PATIENT'S CURRENT MEDICATIONS

Ocular Meds:			Med. Allergies:	
List of **YOUR MEDICATIONS** and why you take them.				
Patient Initials and Date	**1#** Initl. [ ] Date:	**2#** Initl. [ ] Date:	**3#** Initl. [ ] Date:	**4#** Initl. [ ] Date:

For additional meds, or meds no longer taken, document change and date of change in this area.

Your "PERSONAL" Health History

Health Conditions	**NO** (check column below "NO" if it does not apply)		DATE REVIEWED			
CONSTITUTIONAL		Fever, Weight Loss, Fatigue, Developmental Disability, Other				
EAR, NOSE, THROAT		Sinus, Chronic Cough, Upper Respiratory Tract Infection, Other				
CARDIOVASCULAR		**HBP,** Heart Disease, Stroke, Poor Circulation, **High Chol,** Other				
ENDOCRINE		**Diabetes, Thyroid,** hormonal dysfunction, Other				
RESPIRATORY		Cigarette Smoker, Asthma, bronchitis, emphysema, Other___				
GASTROINTESTINAL		Ulcer, Crohn's, Colitis, Digestive Probs, Other_____				
GENITOURINARY		STD- viral, hepatic Urinary Problems, Other_____				
MUSCULOSKELETAL		arthritis, fibromyalgia, ankylosing spondylitis, Other_____				
INTEGUMENTARY		Dermatitis **Rosacea** Other_____				
NEUROLOGICAL		**Multiple Scle**r Headaches Migraines Seizures Other_____				
PSYCHIATIC		Anxiety, Depression, Bipolar, schizophrenia, Other_____				
BLOOD / LYMPHATIC		anemia, leukemia, large volume blood loss, other_____				
IMMUNOLOGIC / ALLERGIC		drug allergy, environmental allergy, Rheum Arthritis, lupus, other				
(Use this box to explain "OTHER" conditions)		Patient Initials and Date	**#1**	**#2**	**#3**	**#4**

Notice of Privacy Practices (to be signed in office)

I acknowledge that I have had the opportunity to review the Notice of Privacy Practices for Cargill Eyecare Wexford. I have also been offered a copy.

Patient Signature_____ Date_____