Patient Health History

Please note any health problems below:

The information in this confidential health history is critical to

the evaluation of your vision and ocular health.



COLUMBUS OHIO EYE CARE

A MEMBER OF VISION SOURCE

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Constitutional (cancer, developn	nental dis	abilities, etc)						
Ears, Nose, Throat (hearing los	s, sinusiti	s, etc)						
Neurological (MS, migraine, vert	igo/dizzin	ness, etc)						
Psychological (depression, bipo								
Cardiovascular (blood pressure,								
Respiratory (asthma, bronchitis,								
Gastrointestinal (acid reflux, Cro								
Genitourinary (kidney disease, p								
Musculoskeletal (arthritis, osteo	porosis, e	etc)						
Dermatological (eczema, psoria								
Endocrine (diabetes, thyroid, etc								
	Year Diagnosed:							
Last fasting blood sugar								
Hematological / Lymphatic (and								
Allergy / Immunology (lupus, Sj								
Primary Care Physician:								
Please list any medications yo								
Allergies:								
Height: Weight:			Please indicate if you or any of your blood relatives have a					
			medical or ocular history in the following areas:					
Date of last eye exam:								
Currently wear glasses?	YES	NO	Cancer	Self	Mom	Dad	Brother	Sister
Currently wear contact lenses?	YES	NO	Diabetes	Self	Mom	Dad	Brother	Sister
Are you pregnant or nursing?	YES	NO	Hypertension	Self	Mom	Dad	Brother	Sister
Do you use tobacco?	YES	NO	Thyroid	Self	Mom	Dad	Brother	Sister
Amount:			Cataracts	Self	Mom	Dad	Brother	Sister
Do you drink alcohol?	YES	NO	Glaucoma	Self	Mom	Dad	Brother	Sister
Amount:	\		Macular Degeneration	Self	Mom	Dad	Brother	Sister
Do you use other substances?	YES	NO	Dry Eye	Self	Mom	Dad	Brother	Sister
Amount:			Lazy Eye	Self	Mom	Dad	Brother	Sister
			Retinal Detachment	Self	Mom	Dad	Brother	Sister