Complete Family EyeCare, LLC

Health History Form

Please fill out the health history form as accurately as you can. All information is kept confidential.

Name: _________________________________ Date of Birth: _____________

Review of Systems:
Please check the box next to conditions you have been treated for.

Diabetes ______
Thyroid ______
Depression ______
Panic Disorder ______
Crohn's ______
Colitis ______
Allergies ______
Arthritis ______
STD ______
Trauma ______
Weight Loss ______
Headache ______
Eczema ______
Rosacea ______
Psoriasis ______
Asthma ______
Emphysema ______

Anemia ______
Multiple Sclerosis ______
Epilepsy ______
Heart Disease ______
Hypertension ______
Cholesterol ______
Ear, Nose and Throat ______
Fibromyalgia ______
Ankylosing Spondylitis ______
Other: ___________________

Ocular:
Glaucoma ______
Cataract ______
Macular Degeneration ______
Strabismus ______
Amblyopia ______
Other: _________________

List any surgeries and dates:

____

____

Smoking History:
Do you currently smoke? ________ Everyday? _______
Did you formerly smoke? ________

Family History:
Are any immediate family members being treated for medical or ocular conditions? Please answer yes or no and indicate relation.

Diabetes _________
Hypertension___________
Other: ___________________

Glaucoma ________
Macular Degeneration_________
Cataract _________
Retinal Disease ______________
Other: _________________

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Please list all medications you are currently taking, including over the counter. Attach a list of medications if you need more space.

Name	Reason for Taking

Are you allergic to any medications? Please list:

____

Women:
Are you pregnant? _____________
Due Date: _____________________
Are you breastfeeding? __________

Primary Care Physician:
Name: ___________________________________
Street Address: ___________________________
City: ______________________ State: _________ Zip Code: _________
Phone: ____________________

Pharmacy:
Name: ___________________________________
Street Address: ___________________________
City: ______________________ State: _________ Zip Code: _________
Phone: ____________________