ACHIEVE EYE & LASER SPECIALISTS

Name: _____ Today's Date: _____

Family Physician: _____ Birthday: _____

How were you referred? _____

MEDICATIONS

Eye Drops: Pills and other medicines: Drug Allergies:

PAST OCULAR HISTORY
(when appropriate, list dates and eye involved)

List all eye problems or previous eye Injuries:	List all eye surgeries:

PAST MEDICAL HISTORY

Do you have any of the following medical illness? (check all that apply): ☐ High blood pressure ☐ Diabetes ☐ Heart disease ☐ Asthma ☐ Depression ☐ Stroke ☐ Clotting disorder ☐ AIDS ☐ Cancer	List any other medical illness or major surgery:

PERSON/SOCIAL/FAMILY HISTORY

Smoking History: ☐ Y ☐ N # of packs/day? _____ #of years? _____
Social History: Marital Status: _____ Occupation: _____
Family History (please check all that apply):

☐ Retinal detachment	☐ Loss of vision at a young age	☐ Cataract
☐ Macular degeneration	☐ Congenital defects	☐ Diabetes
☐ Corneal transplant	☐ Blood clotting problems	
☐ Glaucoma	☐ Heart disease	

Please complete other side:

_____
Physician signature/Date

Achieve Eye & Laser Specialists
Health History Form

Please circle what pertains to your health or **NONE** if none applies to each category.

Patient Name: _____ Today's Date; _____

- Constitutional: ☐ headaches, ☐ fatigue, ☐ fever, ☐ insomnia, ☐ weight loss, ☐ weight gain**,** ☐ none, or other: _____
- HEENT (Head, Ears, Nose, Throat): ☐ hearing loss, ☐ hoarseness, ☐ nasal congestion, ☐ pain, ☐ sore throat, ☐ ringing in ears, ☐ dizziness, ☐ none, or other: _____
- Respiratory: ☐ asthma, ☐ shortness of breath, ☐ cough, ☐ coughing up blood, ☐ TB exposure, ☐ none, or other: _____
- Cardiovascular (Heart): ☐ palpitations, ☐ chest pain, ☐ history of heart attack, ☐ none, or other: _____
- Vascular: ☐ ankle swelling, ☐ circulation problems, ☐ leg ulcer, ☐ none, or other: _____
- Gastrointestinal: ☐ abdominal pain, ☐ constipation, ☐ diarrhea, ☐ vomiting, ☐ nausea, ☐ acid reflux, ☐ none, or other: _____
- Genitourinary: ☐ incontinence, ☐ kidney stones, ☐ blood in urine, ☐ pain with urination, ☐ bladder infections, ☐ none, or other: _____
- Reproductive: For Female patients only: Are you pregnant? _____
- Metabolic/Endocrine: ☐ weight gain/loss, ☐ increased thirst, ☐ increased urination, ☐ generalized weakness, ☐ hair loss, ☐ blood sugar abnormalities (explain), ☐ none, or other: _____
- Neurological/Psychiatric: ☐ anxiety, ☐ dementia, ☐ depression, ☐ dizziness, ☐ headaches, ☐ migraines, ☐ memory loss, ☐ stroke, ☐ numbness of extremities, ☐ tremors, ☐ seizures, ☐ dizziness, ☐ Alzheimer's, ☐ none, or other: _____
- Dermatological (Skin): ☐ acne, ☐ contact allergy, ☐ eczema, ☐ hair loss, ☐ pigment changes, ☐ rashes, ☐ skin lesions, ☐ none, or other: _____
- Musculoskeletal: ☐ back pain, ☐ bone/joint symptoms, ☐ muscle pain, ☐ rheumatism, ☐ none, or other: _____
- Hematological (Blood): ☐ bruises easily, ☐ HIV virus, ☐ prior transfusion, ☐ none, or other: _____
- Immunological: ☐ asthma, ☐ bee sting allergies, ☐ environmental allergies, ☐ food allergies, ☐ hay fever, ☐ none, or other: _____
- Have you ever taken steroid medication of any kind? ____ (If so, why? _____)
- Are you taking aspirin, aspirin related products or blood thinners? _____
- Any other conditions we should be aware of? _____ _____

Physician Signature / Date: _____