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.	Cataracts ( ) Glaucoma ( ) Mac Degen ( ) Ret.Detach ( ) Hbp ( ) High Chol ( ) Diabetes ( ) Thyroid ( ) Other ( ) ***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)**

Health Conditions	NO		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______________