BOSTON EYE CARE CONSULTANTS
PATIENT HEALTH HISTORY

PLACE PATIENT LABEL

PRIMARY CARE PHYSICIAN: ____________________

PRIMARY PHARMACY: ____________________

EMERGENCY CONTACT: ____________________

ALLERGIES (BE SPECIFIC PLEASE): ____________________

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SOCIAL HISTORY(this will be reviewed annually)

Do you smoke? YES NO

How much do you smoke or chew tobacco per day: ____________________

Did you ever smoke? YES NO When did you quit: ____________________

Do you drink alcohol? YES NO

If yes, how many drinks do you have per day: ____________________

Work Status: ____________________ **Occupation:** ____________________

Living arrangements: HOME APARTMENT NURSING FACILITY OTHER

Are you in Hospice Care: YES NO

Do you live alone: YES NO Status: INDEPENDENT NEED ASSISTANCE

Are there social problems affecting your Health(family, deaths, stress, etc.): YES NO

Do you drive during the day: YES NO Difficulty: YES NO

Do You Drive at night: YES NO Difficulty: YES NO

SURGICAL HISTORY:

Please list any surgical procedures: ____________________

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Have you had previous EYE surgery/laser or injury: YES NO

If YES, please list what you have had including dates and which eye affected: ____________________

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Date of last General anesthesia: ____________________ **Any complications: YES NO**

CANCER: YES NO TYPE: LOCATION: DATE:

TREATMENT: ____________________

DIABETES: YES NO TYPE: DATE OF ONSET:

Treatment: ____________________

MEDICAL HISTORY (Please be sure to answer each question)

How would you rate your Health: POOR FAIR GOOD EXCELLEN

Do you have now or have had the following:

Condition			
Fever, Chills, night sweats, fatigue?	YES	NO	EXPLAIN:
Unexplained weight gain on loss?	YES	NO	EXPLAIN:
Ear, nose throat problems?	YES	NO	EXPLAIN:
Heart problems/Irregular beat?	YES	NO	EXPLAIN:
Circulation problems?	YES	NO	EXPLAIN:
Cardiac pacemaker/Heart Valve?	YES	NO	EXPLAIN:
Breathing problems?(athma,TB,etc)	YES	NO	EXPLAIN:
Ulcers, colitis, diverticulitis?	YES	NO	EXPLAIN:
Liver disease?	YES	NO	EXPLAIN:
Hepatitis? Type:	YES	NO	EXPLAIN:
Kidney, Bladder, prostate problems?	YES	NO	EXPLAIN:
Arthritis? Type:	YES	NO	EXPLAIN:
Rosacea, shingles?	YES	NO	EXPLAIN:
TIA, Stroke, Seizure?	YES	NO	EXPLAIN:
Depression, Anxiety?	YES	NO	EXPLAIN:
Thyroid disease?	YES	NO	EXPLAIN:
Blood disorders? Anemia, clots	YES	NO	EXPLAIN:
Have you had a blood transfusion?	YES	NO	EXPLAIN:
AIDs, ARC or HIV positive?	YES	NO	EXPLAIN:
Are you pregnant?	YES	NO	HOW FAR ALONG:

FAMILY HISTORY Blood Relatives

Condition			
Glaucoma	YES	NO	EXPLAIN:
Cataracts	YES	NO	EXPLAIN:
Muscle Imbalance	YES	NO	EXPLAIN:
Retinal Disease	YES	NO	EXPLAIN:
Macula Disease	YES	NO	EXPLAIN:
Color Blind	YES	NO	EXPLAIN:
Vision Loss	YES	NO	EXPLAIN:

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Patient Signature:______________________ * **Date:**__________

Physician Signature:______________________