**BOSTON EYE CARE CONSULTANTS**

**PATIENT HEALTH HISTORY**

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| PLACE PATIENT LABEL |

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| BARCODE |

PRIMARY CARE PHYSICIAN:

LOCAL PHARMACY:

EMERGENCY CONTACT:

ALLERGIES (BE SPECIFIC PLEASE):

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| **SOCIAL HISTORY(this will be reviewed annually)**   1. 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: 2. Do you drink alcohol? YES NO    * If yes, how many drinks do you have per day: 3. Work Status: Occupation: 4. Living arrangements: HOME APARTMENT NURSING FACILITY OTHER    * Are you in Hospice Care: YES NO 5. Do you live alone: YES NO Status: INDEPENDENT NEED ASSISTANCE 6. Are there social problems affecting your Health(family, deaths, stress, etc.): YES NO 7. Do you drive during the day: YES NO Difficulty: YES NO 8. Do You Drive at night: YES NO Difficulty: YES NO |
| **SURGICAL HISTORY**  **Please list any surgical procedures:**  **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:**  **Date of last General anesthesia: Any complications: YES NO**  CANCER: YES NO TYPE: LOCATION: DATE:  TREATMENT:  DIABETES: YESNO TYPE: DATE OF ONSET:  **Treatment:** |

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| **MEDICAL HISTORY (Please be sure to answer each question)**  How would you rate your Health: POOR FAIR GOOD EXCELLENT  Do you have now or have had the following:  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**  Glaucoma  **YES NO EXPLAIN:**  Cataracts **YES NO EXPLAIN:**  Muscle Imbalance **YES NO EXPLAIN:**  Retinal Disease **YES NO EXPLAIN:**  Macula Disease **YES NO EXPLAIN:**  Color BlindYES **NO EXPLAIN:**  Vision Loss **YES NO EXPLAIN:**  **Patient Signature: Date:**  **Physician Signature:** |