**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
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| **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:**  |