myeye consultants

HEALTH HISTORY

Patient Name: _____ Age _____ Date _____

Please fill out or check any of the following
that apply to you now or in the past

Name of Family Doctor _____ Date last visited: _____

Location of Doctor: _____

ALLERGIES to medications/Substances: _____

Weight: _____ (lbs) Height: _____ (ex.5ft, 6in)

CONSTITUTION:
___Fatigue Syndrome
___Developmental Disabilities
___Cancer
___Other: _____

EAR/NOSE/THROAT:
___Hearing Loss
___Laryngitis
___Dry Mouth
___Sinusitis
___Other: _____

NEUROLOGICAL:
___Tumor
___Epilepsy
___Multiple Sclerosis
___Cerebral Palsy
___Other: _____

PSYCHOLOGICAL:
___Depression
___Other: _____

CARDIOVASCULAR:
___ Cogestive Heart Failure
___ Hypertension
___ Stroke
___ Heart Disease
___Other: _____

RESPIRATORY:
___Smoker
___Emphysema
___Chronic Obstruction
___Asthma
___Bronchitis
___Other: _____

GASTROINTESTINAL:
___Colitis
___Ulcer
___Chron's Disease
___Other: _____

GENITOURINARY:
___Prostate Disease/Cancer
___Kidney Disease
___Sexually Transmitted Dz
___Other: _____

MUSCULOSKELETAL:
___ Osteoarthritis
___ Muscular Dystrophy
___ Ankylosing Spondylitis
___ Fibromyalgia
___Other: _____

INTEGUMENTARY:
___ Rosacea
___ Eczema
___ Psoriasis
___Other: _____

ENDOCRINE:
___ Insulin Dependent Diabetes
___ Hormonal Dysfunction
___ Non-Insulin Dependent Diabetes
___ Thyroid Dysfunction
___Other: _____

HEMATOLOGIC/ LYMPHATIC:
___ Hypercholesteremia
___ Large-volume blood loss
___ Anemia
___ Ulcer
___Other: _____

(Continue on Other Side)