# Center For Sight

Gary W Wallace MD
Doug Hilborn OD

**Health History**

**Name:**_____ **Date of Birth**_____ **Today's Date** _____

**Referring Doctor**_____ **Primary Care Doctor**_____

**Date of Last Eye Exam** _____ **Performed by**_____

**Past medical history:**

| | | | |
|---|---|---|---|
| ❑Yes ❑No | …diabetes ___yrs | ❑Yes ❑No | ...cancer |
| ❑Yes ❑No | ...high cholesterol | ❑Yes ❑No | ...seizure |
| ❑Yes ❑No | ...hypertension | ❑Yes ❑No | …COPD |
| ❑Yes ❑No | …thyroid disease | ❑Yes ❑No | …asthma |
| ❑Yes ❑No | ...heart disease | ❑Yes ❑No | ...arthritis |
| ❑Yes ❑No | ...stroke /TIA | ❑Yes ❑No | ...migraine |

**Past surgical history:** **Dates**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

**Personal eye history:** **Family history of:**

| | | | |
|---|---|---|---|
| ❑Yes ❑No | .....glaucoma…..... | ❑Yes ❑No | |
| ❑Yes ❑No | .....cataract…..... | ❑Yes ❑No | |
| ❑Yes ❑No | ……..mac degeneration…..... | ❑Yes ❑No | |
| ❑Yes ❑No | ……..diabetic retinopathy.... | ❑Yes ❑No | |
| ❑Yes ❑No | .....dry eyes..... | ❑Yes ❑No | |
| ❑Yes ❑No | …….eye muscle surgery…..... | ❑Yes ❑No | |
| ❑Yes ❑No | …..poor vision since birth….. | ❑Yes ❑No | |
| ❑Yes ❑No | ……..retinal detachment…..... | ❑Yes ❑No | |
| ❑Yes ❑No | .....eye trauma..... | ❑Yes ❑No | |

**Past eye surgical history:** **Dates**

_____ _____
_____ _____
_____ _____
_____ _____

**Allergies:**

Do you have any known drug allergies? ❑Yes ❑No

List them_____

**Social History:**

Current weight _____ Current height _____

| | | | |
|---|---|---|---|
| Recent weight changes?... | ❑Yes | ❑No | gain(____lbs) los(____lbs) |
| Do you smoke?..... | ❑Yes | ❑No | packs per day? _____ |
| Do you drink alcohol?..... | ❑Yes | ❑No | how often?_____ |
| Do you exercise?..... | ❑Yes | ❑No | how often?_____ |
| Do you drive?..... | ❑Yes | ❑No | gain(____lbs) los(____lbs) |

**Anesthesia history:**

Have you had any complications from anesthesia?
❑Yes ❑No _____

Have you or a close relative been diagnosed with malignant hyperthermia?
❑Yes ❑No / unknown

**Review of systems: Do you currently have any of the following problems?** **If yes, please explain**

| | | | |
|---|---|---|---|
| Allergic/immunologic (arthritis, asthma, immune deficiency)..... | ❑Yes | ❑No | _____ |
| Chronic fever, unexpected weight loss / gain, fatigue..... | ❑Yes | ❑No | _____ |
| Ear / nose / throat problems (hearing loss, sinus problem, sore throat)..... | ❑Yes | ❑No | _____ |
| Endocrine (thyroid, diabetes)..... | ❑Yes | ❑No | _____ |
| Eyes (tearing, painful)..... | ❑Yes | ❑No | _____ |
| Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomiting)……. | ❑Yes | ❑No | _____ |
| Heart Problems (chest pain,irregular heart beat)..... | ❑Yes | ❑No | _____ |
| Hematologic/ lymphatic (anemia, frequent infections, bleeding problems)..... | ❑Yes | ❑No | _____ |
| Musculosketal problems (muscle aches, joint pain, swollen joints)..... | ❑Yes | ❑No | _____ |
| Neurologic problems (vertigo, numbness, weakness, headaches, paralysis)……. | ❑Yes | ❑No | _____ |
| Psychiatric problems (depression, anxiety)..... | ❑Yes | ❑No | _____ |
| Respiratory problems (shortness of breath, wheezing, coughing)..... | ❑Yes | ❑No | _____ |
| Skin problems ( rashes, excessive dryness)..... | ❑Yes | ❑No | _____ |
| Urinary problems (pain or discomfort, blood in urine)..... | ❑Yes | ❑No | _____ |

**Patient signature: (Please complete the back of this form before signing)**

_____ _____ _____ _____
Patient or guardian signature Date Updated by patient or guardian Date

_____ _____ _____ _____
Patient or guardian signature Date Updated by patient or guardian Date