

# HEALTH HISTORY

Name: \_\_\_\_\_

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Date: \_\_\_\_\_ DOB: \_\_\_\_\_

Referred by: \_\_\_\_\_

Your Health History is an important part of your patient record and required by almost every insurance company. Please help us by completing this form in detail before your next appointment. Thank you.

## I. Review of Systems

### EYES

Loss of Vision	Y	N	Redness	Y	N
Double Vision	Y	N	Itching	Y	N
Blurred Vision	Y	N	Foreign Body Sensation	Y	N
Visual Difficulty			Eye Pain	Y	N
When driving	Y	N	Sties, Chalazion	Y	N
Problem with night			Glaucoma	Y	N
Vision	Y	N	Cataracts	Y	N
			Burning	Y	N
			Excess tearing/watering	Y	N
			Dryness	Y	N
			Other: _____		

Any eye operations? Type? Date? \_\_\_\_\_

Any eye injury? Kind? Date? \_\_\_\_\_

Explain "Yes" answer: \_\_\_\_\_

### RESPIRATORY

Asthma	Y	N
Emphysema/COPD	Y	N
Seasonal Allergies	Y	N
Tuberculosis	Y	N
Shortness of Breath	Y	N

### CARDIOVASCULAR

High Blood Pressure	Y	N
Heart Attack/Coronary		
Artery Disease	Y	N
Angioplasty/Bypass Surgery	Y	N
Heart Murmur	Y	N
Congestive Heart Failure	Y	
Slow or Fast Heart Rate	Y	N
Bleeding Problems	Y	N
Stroke/TIAs	Y	N
Cholesterol	Y	N

### SYSTEMIC

Diabetes	Y	N
Thyroid	Y	N
Kidney Disease	Y	N
Hepatitis/Yellow		
Jaundice	Y	N
Intestinal Problems	Y	N
Convulsions//Seizures/		
Blackouts	Y	N
Stomach Ulcers	Y	N
Migraines	Y	N
Headaches	Y	N

### OTHER:

Allergic/Immunologic	Y	N
Cancer	Y	N
Arthritis	Y	N
HIV/AIDS	Y	N

OTHER: \_\_\_\_\_

