John Day EYE CARE
A MEMBER OF VISION SOURCE®

PATIENT HEALTH HISTORY

Last Name:_____ First Name:_____ DOB:_____ Sex:_____

Date:_____ Reason for visit: _____

REVIEW OF SYSTEMS

Please check any conditions that you currently have or have a history of, or check none.

CONSTITUTION
- ☐ Cancer
- ☐ Fatigue Syndrome
- ☐ Developmental Disabilities
- ☐ None

ENT
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis
- ☐ None

NEURO
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Stroke/CVA
- ☐ Migraine
- ☐ Autism Spectrum Disorder
- ☐ None

Psych
- ☐ Depression
- ☐ Attention Deficit
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ None

CARDIO
- ☐ Hypertension
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart Failure
- ☐ None

RESPIRATORY
- ☐ Cigarette Smoker
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstruction
- ☐ Sleep Apnea
- ☐ None

GI
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux
- ☐ Celiac Disease
- ☐ None

GU
- ☐ Kidney Disease
- ☐ Prostate Disease/Cancer
- ☐ STD - herpetic/chlamydia
- ☐ Benign Prostate Hypertrophy
- ☐ Pregnant
- ☐ Nursing
- ☐ None

MUSC/SKEL
- ☐ Osteoarthritis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Gout
- ☐ None

INTEG
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Herpes Simplex/Cold Sores
- ☐ Herpes Zoster/Shingles
- ☐ None

ENDO
- ☐ Type 2 Diabetes Mellitus
- ☐ Type 1 Diabetes Mellitus
- ☐ Thyroid dysfunction
- ☐ Hormonal dysfunction
- ☐ None

If Diabetic:

Last A1C: _____

Year Diagnosed: _____

HEM/LYMPH
- ☐ Anemia
- ☐ Large-volume blood loss
- ☐ Ulcer
- ☐ Hypercholesteremia
- ☐ None

ALLERGY/IMM
- ☐ Drug Allergies
- ☐ Environmental Allergies
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Sjogren's Syndrome
- ☐ None

Other: _____

_____

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EYE SURGERIES/LASER TREATMENTS

Type of Operation: Date: Complications:

_____

_____

MEDICATIONS Please list any medications including eye drops/supplements/vitamins that you take

Medication Name:	**Dosage:**

Drug Allergies: _____

_____

Latex Sensitivity? Y ☐ N ☐

Social History:

Alcohol Y ☐ N ☐ Number per week: _____

Tobacco Y ☐ N ☐ Number per day: _____ How Long: _____ Smokeless Tobacco Y ☐ N ☐

Have you ever used tobacco in the past? Y ☐ N ☐ Approx start date: _____ Date Stopped: _____

Hobbies/Special Interests: _____

_____

Family Medical History:

	Mother	Father	Brother	Sister	Son	Daughter	None
Diabetes mellitus in first degree relative							
Family history of diabetes mellitus type 1							
Family history of diabetes mellitus type 2							
Family history of hyperthyroidism							
Family history of hypothyroidism							
Family history of cancer							
Family history of hypertension							
Family history of cataract							
Family history of degenerative disorder of macula							
Family history of glaucoma							

thank you