

Patient History Sheet				Date / /		
Name		Date of Birth / /		SSN / /		
Address		City, State		Zipcode		
Home Phone		Work Phone		email		
Insurance Information						
Responsible Party		Relationship		Address (if different)		
Vision Insurance		Policy #		Group #		
Medical Insurance		Policy #		Group #		
Do you have or have you ever had ...				Family History		
	Yes	No		Does anyone in your family have?	Yes	No
Diabetes				Diabetes		
Since when?				Heart Disease/ Hypertension		
Do you use insulin?				Glaucoma		
High Blood Pressure				Macular Degeneration		
Heart attack				Other Eye disease		
Heart disease						
Arthritis				Are you currently experiencing?		
Cancer				Weight Loss		
Migraine Headache				Weight Gain		
Thyroid disease				Fatigue		
Lung Disease/ Asthma				Fever		
Kidney Disease				Chest pain		
HIV				Swelling of the feet		
TB				Excessive thirst		
Syphilis				Shortness of breath		
Allergies to Medication				Wheezing		
				Coughing		
				Headaches		
Previous Surgery? Please list.				Seizures		
				Weakness of extremities		
				Numbness of extremities		
Social History				Decreased hearing		
Do you smoke?				Hearing aid use		
cigarettes / day				Runny nose		
Do you drink alcohol?				Sinus problems		
drinks / week				Sore throat		