LOSSMAN EYE CARE ASSOCIATES

PATIENT HEALTH HISTORY

Patient Name:___________________________________ DOB_____/_____/_______ Gender: M F

Primary Care Physician: ________________________________ Date Last Seen by PCP: ________________

Medical/Family History (use back sheet if more space is needed)

Please list all your current medications (include over the counter, vitamins and herbal therapy):____
____
____

List all major surgeries (Eye Surgery included):____
____

List allergic conditions :(e.g. medications, seasonal, mold, dust, latex, eye drops):______________________________
____
____

Please indicate if any of the conditions apply to you or a family member (blood relatives only).

Disease/Condition	Yourself Yes	Yourself No
Cataract		
Eye Turn		
Glaucoma		
Macular Degeneration		
Retinal Detachment		

	Yes	No
Women are you Pregnant?		
Are you breast feeding?		

	Family Member Yes	Family Member No	Relationship (Blood Relatives Only)
Blindness			______________________
Eye Turn			______________________
Glaucoma			______________________
Macular Degeneration			______________________
Retinal Detachment			______________________

Other:____

Review of Systems Please indicate below if you have or ever had problems with the following conditions:

Allergic/Immunologic
- None
- Lupus (SLE)
- Rheumatoid Arthritis
- Environmental Allergies
- Other

Ear, Nose and Throat
- None
- Sinusitis
- Upper Respiratory Tract Infection
- Other

Gastrointestinal
- None
- Crohn's Disease
- Colitis
- Acid Reflux/Ulcer
- Other

Skin
- None
- Eczema
- Rosacea
- Psoriasis
- Other

Psychiatric
- None
- Depression
- Bi-Polar
- Schizophrenia
- Other

Cardiovascular
- None
- High Blood Pressure
- Heart Disease
- Stroke
- Vascular Disease

Endocrine/Glands
- None
- Diabetes
- Hormone Dysfunction
- Thyroid Dysfunction
- Other

Respiratory
- None
- Asthma
- Bronchitis
- Emphysema
- Other

Muscle/Skeletal
- None
- Arthritis
- Fibromyalgia
- Ankylosing Spondylitis
- Other

Genital/Urinary
- None
- Urinary Tract Infection
- HIV Positive
- Herpes/Chlamydia
- Other

Hematologic/Lymphatic
- None
- Anemia
- Leukemia
- Bleeding Disorder
- Other

Neurological
- None
- Multiple Sclerosis
- Epilepsy
- Tremors
- Other

General Health
- None
- Weight loss/gain
- Fever
- Fatigue
- Trauma

Social
- Tobacco Use:
- Current Smoker Previous Smoker
- Non-Prescription Drugs______________________
- Alcohol Consumption______________________
- Weight________________ Height___________

Please sign below to acknowledge that this form is current:

Signature:____ Date:________________________ Reviewed by Doctor's initials :___________

Acknowledgement of Receipt of Notice of Privacy Practices

My signature below verifies that I have received a copy of the Lossman Eye Care Associates Notice of Privacy Practices.

Name of Patient (Print)____ Signature of Patient:______________________________Date:__________

Signature of Patient Representative (if patient is a minor or an adult unable to sign this form)

Relationship of Patient Representative to Patient ____

Revised 07/11/2011