HESTER OPHTHALMOLOGY

Today's Date: _____

Patient Name: _____ **Date of Birth:** _____

To help us serve your eye care needs it is important that we have accurate information regarding your general medical health. Please complete this form as thoroughly as possible. Thank you.

Primary Care Doctor: _____ Cardiologist: _____

Optometrist: _____ Endocrinologist: _____

Other Physicians: _____

General Health History

Do you have any history of the following?	**No**	**Yes**	How recent?	**Family History?** (which relative)
Arthritis	☐	☐	_____	☐ _____
Anemia or Bleeding Disorder	☐	☐	_____	☐ _____
Cancer or Thyroid issues	☐	☐	_____	☐ _____
Diabetes (Type I or Type II)	☐	☐	_____	☐ _____
Elevated Cholesterol	☐	☐	_____	☐ _____
Heart Disease	☐	☐	_____	☐ _____
Hypertension (high blood pressure)	☐	☐	_____	☐ _____
Hearing Loss	☐	☐	_____	☐ _____
Infectious Disease (HIV, Hepatitis, MRSA, etc.)	☐	☐	_____	☐ _____
Kidney Disease	☐	☐	_____	☐ _____
Migraines	☐	☐	_____	☐ _____
Neuropathy	☐	☐	_____	☐ _____
Sinus issues	☐	☐	_____	☐ _____
Thyroid Disease	☐	☐	_____	☐ _____
Vertigo	☐	☐	_____	☐ _____

List any major surgeries you have had: _____

_____

_____

Prescription and Over-the-Counter Medications

☐ I have a separate list with me (*or* list below)

Name	Dosage	Name	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medication Allergies

☐ None (or listed below)

_____ _____

_____ _____

_____ _____

HESTER OPHTHALMOLOGY

Today's Date: _____

Patient Name: _____ **Date of Birth:** _____

Social History

☐ Never a Smoker

☐ Smoker _____packs/ day for _____years

☐ Former Smoker: year started _____, until_____

☐ Alcohol _____ drinks per day *or* _____ per week

☐ Recreational Drugs _____

Ocular History

Have you had of the following?	**No**	**Yes**	Which eye or both?	**Family History?** (which relative)
Cataracts	☐	☐	_____	☐ _____
Age Related Macular Degeneration	☐	☐	_____	☐ _____
Wet Macular Degeneration	☐	☐	_____	☐ _____
Glaucoma	☐	☐	_____	☐ _____
Retinal Detachment	☐	☐	_____	☐ _____
Diabetic Retinopathy	☐	☐	_____	☐ _____
Astigmatism	☐	☐	_____	
Double Vision	☐	☐	_____	

Past Eye Surgeries

☐ Cataract Surgery

☐ Glaucoma Surgery (SLT, Trab, Stint)

☐ Eye Muscle Surgery

☐ LASIK

☐ Oculoplastic Surgery

☐ Other _____

Are you experiencing any of the following now?

Symptom	**No**	**Yes**	**Notes**
Fever or Chills	☐	☐	_____
Fatigue	☐	☐	_____
Sudden weight loss	☐	☐	_____
Headaches	☐	☐	_____
Weakness or Numbness	☐	☐	_____
Memory Loss	☐	☐	_____
Joint Pain or Swelling	☐	☐	_____
Stiffness	☐	☐	_____
Muscle Pain	☐	☐	_____
Back Pain	☐	☐	_____
Heat or Cold Intolerance	☐	☐	_____
Frequent Urination	☐	☐	_____
Chest Pain	☐	☐	_____
Shortness of Breath	☐	☐	_____
Palpitations	☐	☐	_____
Bruising or bleeding	☐	☐	_____

Other Symptoms: _____

Do you have any special needs? ☐ Wheelchair ☐ Walker ☐ Hearing Aids ☐ Other: _____