MargolisVision

State-of-the-Art Center for
Medical, Surgical & Cosmetic Ophthalmology

Health History Review

Date: _____

Patient Name: _____ DOB: _____

To help us serve your eye care needs it is important that we have accurate information regarding your general medical health. Please complete the form below and bring to your appointment. Thank you.

Primary Care Doctor: _____ Phone Number: _____

PAST MEDICAL HISTORY – PLEASE INDICATE PAST ILLNESSES, PROCEDURES OR SURGERIES. YOU MAY ALSO USE THE BACK OF THIS PAGE.

Month _____ Year _____
Details _____
_____

Month _____ Year _____
Details _____
_____

FAMILY HISTORY – PLEASE INDICATE IF CLOSE FAMILY MEMBERS HAVE SUFFERED FROM THE FOLLOWING BY CIRCLING:

Asthma Diabetes Heart Problems High Blood Pressure

High Cholesterol Cancer Stroke Cataracts

DRUGS AND TREATMENT – PLEASE INDICATE ANY MEDICINES YOU ARE CURRENTLY TAKING. YOU MAY ALSO USE THE BACK OF THIS PAGE.

Name of Medicine _____ Dosage _____

Name of Medicine _____ Dosage _____

SOCIAL HISTORY – PLEASE CIRCLE WHICH OPTION MOST CLEARLY REPRESENTS YOU:

I am a smoker. I was a smoker, but I have quit. I have never smoked.

If you have ever smoked, please indicate the frequency: _____

I drink alcohol. I used to drink alcohol, but I have quit. I have never drank alcohol.

If you have ever drank alcohol, please indicate the frequency: _____