OFFICE USE:_____

TUSCARAWAS EYE CENTRE, INC.
HEALTH HISTORY

Print Name: _____ **Date:** _____

Please check the Yes (Y) or No (N) box

Ear, Nose, Mouth,Throat	Y	N
Allergies		
Hearing Impaired		
Sinus Congestion		
List Other:		

Cardiovascular	Y	N
High Blood Pressure		
Heart Problems		
Stroke		
High Cholesterol		
Carotid Artery Disease		
List Other:		

Respiratory	Y	N
Shortness Of Breath		
Asthma/Emphysema/ COPD **(circle)**		
Sleep Apnea		
List Other:		

Gastrointestinal	Y	N
Crohn's Disease		
Acid Reflux / GERD		
Irritable Bowel/ Colitis		
Stomach Ulcer		
List Other:		

Musculoskeletal	Y	N
Arthritis		
Fibromyalgia		
List Other:		

Skin	Y	N
Acne Rosacea		
Dermatitis/Eczema/Psoriasis (circle one)		
List Other:		

Neurologic	Y	N
Alzheimer's/Dementia		
Headache/ Migraines		
Multiple Sclerosis		
Parkinson's		
List Other:		

Endocrine	Y	N
Diabetes Year Diagnosed:_____		
Thyroid Problem		
Pituitary Problem		
List Other:		

Immunologic	Y	N
Hepatitis		
Sjorgren's		
HIV/AIDS		
Temporal Arteritis/Giant Cell		
List Other:		

Cancer	Y	N
Type:		

Genitourinary	Y	N
Endometriosis		
Frequent Urination		
Prostate Problems		
Sexual Transmitted Disease		
List Other:		

Eyes	Y	N
Retina Disease		
Crossed Eyes		
Lazy Eye		
Iritis		
Corneal Disease		
Glaucoma		
Injury		

Cataracts	Y	N
Surgery		
If yes: When: _____		
Name of Surgeon:_____		
Follow Up Laser?	Y	N

Other Laser Surgery	Y	N
Retina		
Glaucoma		

Please Turn Over to Complete the Back of this Form ⇨

OFFICE USE:_____

Drug Allergies- if yes: list

_____

_____

_____

_____

_____

	Y	N
Latex Allergy		
Adhesive Tape Allergy		
Aspirin Allergy		

Please list ANY past surgeries

_____

_____

_____

_____

_____

Do you use?	Y	N
Alcohol		
If yes: how much per week?_____		
Tobacco		
If yes: How much per week?_____		
Recreational Drugs		
If yes: how much per week?_____		

	Y	N
Do you take Plaquenil/Hydroxychloroquine?		
Do you or have you ever taken Flomax/ Tamsulosin?		

List any medication (including eye drops)

Prescription/ Over the counter

If need more room please attach list	Dose	Frequency

Glasses

Do you wear glasses? **(circle)**

All the time Distance only Reading only

When & where did you purchase glasses?

Contacts	Y	N
Do you wear contacts?		

Brand:_____

Power:**R** _____ **L** _____

Lasik/ PRK/RK (Please Circle)

If yes: When:_____

Name of Surgeon/ location:_____

Has any relative been treated for any of the following? (Relationship to patient)

F-Father M- Mother S-Sister B- Brother

	Y	N	Relation		Y	N	Relation
Glaucoma				**Heart**			
Cataracts				**Retinal Detachment**			
Cornea Disease				**Stroke**			
Macular Degeneration				**Diabetes**			
Retinitis Pigmentosa				**Diabetic Retinopathy**			
Other eye problems							