PATIENT HEALTH HISTORY

Patient Name: _____ **DOB**____/____/_____ **Gender:** M F **Race:** White / Hispanic / Asian

African Am / Am Indian or Alaska Native / Native HI or Other Pacific Islander **Ethnicity**: Hispanic or Latino / Native HI or Other Pac. Is / Not Hispanic or Lat.

Preferred Language: English / Spanish **Contact Information**: Email: _____

Address: _____ Phone: _____

Primary Care Physician: _____ Date Last Seen: _____ Occupation: _____

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 any allergic reactions to **medications or eye drops**: _____

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

Disease/Condition	**Yourself** Yes	No		Yes	No
Cataract	▪	▪	Women- Are you pregnant?	▪	▪
Eye Turn	▪	▪	Are you breast feeding?	▪	▪
Glaucoma	▪	▪			
Macular Degeneration	▪	▪	Contact Lens use?	▪	▪
Retinal Detachment	▪	▪			
	Family Member Yes	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
- Seasonal Allergies
- Other (i.e., Latex)

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

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

Skin/Integumentary
- None
- Eczema
- Rosacea
- Psoriasis
- Other

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

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

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 / Former Smoker / None
- 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 Dr. Lisa A. Hopkins Notice of Privacy Practices for Dr. Hopkins eye care office**.**

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 _____