PHONE 805-569-1000 ROBERT A. KOLARCZYK, MD FAX 805-569-1155

HEALTH HISTORY FORM

PATIENT NAME_____ DOB____/____/____ Phone #_____

Preferred Pharmacy _____ Last Exam: _____ Last Physical _____

TO HELP US MEET ALL YOUR HEALTHCARE NEEDS, PLEASE FILL OUT THIS FORM COMPLETELY.

1. PAST MEDICAL HISTORY – Have you ever had the following: ❑ No Pertinent Past Med History

	Dates		Dates		Dates
❑ Cataracts	_____	❑Crossed Eye	_____	❑ Glaucoma	_____
❑ Dry Eye Syndrome	_____	❑ Macular Degeneration	_____	❑ Lazy Eye	_____
❑ Diabetes	_____	❑ Blood Pressure	_____	❑ High Cholesterol	_____
❑ Thyroid Disease	_____	❑ Other	_____	❑ Other	_____

2. PAST SURGICAL HISTORY – Have you ever had the following: ❑ No Pertinent Surgeries

(PLEASE LIST ALL SERIOUS ILLNESSES, OPERATIONS & OTHER HOSPITALIZATIONS YOU HAVE EXPERIENCED AND INDICATE YEAR.)

❑ Cataract Surgery	❑ LASIK	❑ Glaucoma-Op	❑ Lid Surgery	❑ Retinal Laser Surgery
❑ Tonsillectomy	❑ Appendectomy	❑ C-Section	❑ Hysterectomy	❑ _____

3. Current Medications / Dosage ❑ No Pertinent Medication

CURRENT MEDICATIONS:	DOSAGE (mg)	How often per day?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Drug Allergies: Reactions

_____ _____

_____ _____

5. FAMILY HISTORY: Relationship

❑ History of Cataract? _____

❑ History of Glaucoma? _____

❑ History of Macular Degeneration? _____

❑History of Blood Pressure? _____

❑ History of Diabetes? _____

6. SOCIAL HISTORY:

Do you use tobacco? _____ How many packs per day? _____ for how long? _____

Do you drink alcohol? _____ How many drinks per day? _____ per week? _____ per month? _____

Do you use recreational drugs? _____ If yes, what kind? _____

Marital Status: Single Married Separated Divorced Widowed

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(Please complete the back portion of this form.)

PATIENT NAME_____ DOB____/____/____ Phone #_____

7. REVIEW OF SYSTEMS:

DO YOU HAVE NOW OR HAVE YOU HAD ANY OF THE BELOW PROBLEM WITHIN THE PAST YEAR:

(Please circle anything for which you have a history of)

Constitutional:	fever	chills	fatigue	weight change
Eyes:	blurred vision double vision	vision change swelling	eye pain itching	infection redness
HENT:	headaches	sore throat	ear pain	
Cardiovascular:	heart ailments	chest pain	leg swelling	
Respiratory:	wheezing	breathing problem	shortness of breath	
Gastrointestinal:	nausea	vomiting	abdominal pain	
Integument:	rash	new lesion		
Neurological:	tingling	numbness	weakness	
Psychiatric:	anxiety	depression		
Blood-Lymph:	easy bleeding	easy bruising		
Allergic- Immunologic:	seasonal allergies			

Signature: _____ Date: _____