Bloomfield Eye Associates "Patient Health History"

Date:

Patient Name:		**Date of Birth:**	
Primary Care Physician		**Physician phone #**	
Reason for Last Eye Exam			
Last Eye Doctor		**How long since your last eye exam?**	

Review Of Systems	
List any current illnesses, symptoms or problems	
Constitution	
Cardiovascular	
Ears, Nose, Mouth, Throat	
Respiratory / Lungs	
Stomach / Intestines	
Urinary / Reproductive	
Bones / Joints / Muscles	
Skin / Hair / Nails	
Neurological	
Psychiatric	
Endocrine / Hormonal	
Blood / Circulation	
Allergic / Immunologic	
Other	

Are you pregnant and/or nursing?		**Due Date**	

Surgical History		
Date	**Procedure / Surgeon**	**Complications**

Ocular History		
Ocular Condition / Additional Details (Lazy eye, catarcts, glaucoma, retinal disease, infections, injury)	**Age Began**	**Year From – Year To**

Do you wear glasses? Yes No

Other Personal Information			
Occupation		**Hobbies**	
Do you work on a computer?		**Hours per day**	

Personal Medical History		
Medical Condition / Additional Details	**Age Began**	**Year From – Year To**

Social History		
Description / Additional Details List your social history and detail frequency	**Age Began**	**Year From – Year To**
Exercise:		
Drugs:		
Alcohol Use:		
Other:		

Have you ever been exposed or infected with: HIV AIDS Hepatitis C Gonorrhea Syphillis

Tobacco Status / History		
Current Tobacco Status:	**Age Began**	**Year From – Year To**

Select your tobacco status below if the above status is blank or incorrect:

- ☐ Current everyday smoker
- ☐ Current some day smoke
- ☐ Former smoker
- ☐ Heavy tobacco smoker
- ☐ Light cigarette smoker (1-9 cigs/day)
- ☐ Never smoker
- ☐ Smoker, current status unknown
- ☐ Unknown if ever smoked

Family Medical History			
Family Member	**Medical Condition / Additional Details**	**Age Began**	**Year From – Year To**

Allergies			
Allergy	**Onset Date**	**Reaction**	**Severity**

Contact Lens History					
Type of contact lenses you currently use (gas permeable, soft daily, extended)			**How often do you replace your contacts?** (daily, weekly, monthly)		
Average number of hours that you wear your contacts		**Number of hours worn today**		**Wearing Type** (daily, extended	

Medications

List all prescriptions, over the counter, and herbal medications

Date	Name	Strength	Directions