Please complete the information below, thank you

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Patient #:				Date:		_			
* ,				Patient History Sheet (Pl	HS)	1 :			
Do you now have or have you ever had the following? (circle Yes or No)									
Arthritis Rheumatoid / Deger	nerative	YES	NO	Hepatitis A B or C	YES	NO	Lupus or Sarcoid or TB	YES	NQ
Asthma / Respiratory		YES	NO	HIV / AIDS	YES	NO	Ear Disorders	YES	NO
Cancer type	_	YES	NO	Hyper- or Hypo- Thyroid	YES	NO	Weight Loss	YES	NO
Diabetesyears		YES	NO	Stomach/Intestinal Disease	YES	NO	Fever (prolonged)	YES	NO
Heart Disease		YES	NO	Kidney Disease	YES	NO	Sinus or Seasonal Allergies	YES	NO
High Blood Pressure		YES	NO	Liver Disease	YES	NO	MS	YES	NO
Heart Attack date		YES	NO	Pneumonia	YES	NO	Blood Disorders	YEŞ	NO
High Cholesterol		YES	NO	Stroke date	YES	NO	Anxiety, Depression, Insomnia	YES	NO
Prescription Medications, Herbs	s, Vitan	nins, O	ver the	Counter:					_
Allergies to Medications: OFFICE USE ONLY DIAGNOSIS OD OT									
YOUR EYE HISTORY (circle what applies) Do you now have or have you ever had the following? (circle Yes or No)									
		NO E			140)	3_		-	+
			xplain						
	YES		xplain						
Any past problems with eye Glasses?	YES		xplain: Difficult	to fit, remakes or double vision	n?	5_			+
FAMILY HISTORY Circle Yes or No and list any member of your immediate family: 7									
			Vho:			_ ≥			
			Vho:			ONLY	8	-	+-
			Vho:			USE (+-
Macular Degeneration	YES I	NO V	Vho:						
SOCIAL HISTORY Circle the appropriate answer below.									\pm
Circle the appropriate ans							11		
Use of tobacco Never	When? Current packs per day				12		+-		
Use of alcohol Never	Rarel	у	-	Moderately	. /				工
Updated Tech/Dr	-				1				\dashv
			السساس						