

# Lake Stevens Vision Clinic

## GENERAL HEALTH HISTORY

Name \_\_\_\_\_ Birthday \_\_\_\_\_ Date \_\_\_\_\_

Family Physician \_\_\_\_\_ Physician's Address \_\_\_\_\_

Your Occupation \_\_\_\_\_  Single  Married  Divorced  Widow(er)ed

**CURRENT PROBLEMS:** Do you *currently* have any of the following problems?

	Yes	No			Yes	No	
1	<input type="checkbox"/>	<input type="checkbox"/>	Fever / Weight Loss	12	<input type="checkbox"/>	<input type="checkbox"/>	Joint / Muscle pain
2	<input type="checkbox"/>	<input type="checkbox"/>	Ears / Mouth / Nose / Throat	13	<input type="checkbox"/>	<input type="checkbox"/>	Skin
3	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Disease	14	<input type="checkbox"/>	<input type="checkbox"/>	Headache
4	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	15	<input type="checkbox"/>	<input type="checkbox"/>	Stroke / Neurological disease
5	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat	16	<input type="checkbox"/>	<input type="checkbox"/>	Blood disorders
6	<input type="checkbox"/>	<input type="checkbox"/>	Other heart disease	17	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS
7	<input type="checkbox"/>	<input type="checkbox"/>	Asthma or emphysema	18	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal allergies
8	<input type="checkbox"/>	<input type="checkbox"/>	Other lung disease	19	<input type="checkbox"/>	<input type="checkbox"/>	Reactions to anesthetics
9	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes / Thyroid	20	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric problems
10	<input type="checkbox"/>	<input type="checkbox"/>	Stomach / Intestinal problems	21	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
11	<input type="checkbox"/>	<input type="checkbox"/>	Kidney / Urinary / Genital disease	22	<input type="checkbox"/>	<input type="checkbox"/>	Smoking <input type="checkbox"/> Never

**MEDICATIONS:** List all of the medicines that you take (*do not list eye medicines*)  NONE

**ALLERGIES:** List all allergies *to medicines* that you have and the reaction that it causes  NONE

**ILLNESSES / INJURIES:** List all *past* major illnesses or injuries you have had  NONE

**SURGERIES:** Please list all *past* surgeries (except eye surgeries) that you have had  NONE

**FAMILY HISTORY:** List medical conditions that effect your *parents, siblings or children*  NONE

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_