OPHTHALMIC CONSULTANTS of the Capital Region

Please take a few minutes to fill out our health history form. PLEASE fill in all areas BEFORE YOUR APPOINTMENT and bring this completed form to your next appointment.

Name:_____ **DOB**: ____/____/_____ **Appt Date**: ____/____/_____

Primary Care Provider:		
CURRENT MEDICAL HISTORY: Please check all that apply		
☐ Asthma ☐ Arthritis ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Migraine Headaches ☐ Thyroid Disease	Are you pregnant? ☐ Yes ☐ No Have you had recent head or eye trauma? ☐ Yes ☐ No Did you receive a flu shot? ☐ Yes ☐ No Date of last flu shot?_____ Did you receive a Pneumococcal vaccine? ☐ Yes ☐ No	Are you on blood thinners? ☐ Yes ☐ No Are you on prostate medications? ☐ Yes ☐ No Any other medical problems:

SOCIAL HISTORY: Please circle	
Tobacco Use	Current Former (Quit Year _____) Never
Alcohol Use	Never drink Occasional/social drinker _____ # of drinks per day

Please list past Eye Surgeries	**Please list past surgeries**
1.	**1.**
2.	**2.**
3.	**3.**

CURRENT MEDICATIONS	**Dosage**	**How often?**
EX: Lasix	20 mg.	Twice a day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

List Pharmacy	**Address**	**Phone#**	**Mail Order Pharmacy**