Brainerd Eyecare Center- General Health History

Name:_____Date of Birth:_____ Date:_____

Please indicate any of the following system areas that you experience problems in and what associated medications you are taking: Do you smoke? □ yes □ no

Allergy/Immune System □ none
□ drug allergy
□ seasonal allergy
□ rheumatoid arthritis
□ lupus
□ other_____
medicines_____

Cardiovascular □ none
□ heart disease
□ congestive heart failure
□ stroke
□ high cholesterol
□ high blood pressure
□ other _____
medicines_____
_____
_____

Constitutional/General □ none
□ weight change
□ developmental disability
□ cancer (type)_____
□ sleep apnea
□ other_____
medicines_____

Ears, Nose, Mouth, & Throat □ none
□ sinus problems
□ Sjogren's disease
□ other_____
medicines _____

Endocrine □ none
□ diabetes (how long_____)
□ hyperactive thyroid
□ underactive thyroid
□ Graves disease
□ hormone replacement
□ other
medicines_____

Gastrointestinal (stomach) □ none
□ Crohn's disease
□ colitis
□ ulcer
□ gastric esophageal reflux
□ other _____
medicines_____

List any medicines you are allergic to:

Genito-urinary □ none
□ prostate disease
□ kidney disease
□ other _____
medicines_____

Hematologic/Lymphatic □ none
□ anemia
□ bleeding problems
□ other_____
medicines_____

Skin Disease □ none
□ eczema
□ rosacea
□ other_____
medicines _____

Musculoskeletal □ none
□ fibromyalgia
□ osteoarthritis
□ gout
□ other _____
medicines _____
_____

Neurological □ none
□ multiple sclerosis
□ seizure disorder
□ Parkinson's disease
□ headaches other than occasional
□ other _____
medicines_____

Mental Health □ none
□ depression
□ bipolar disease
□ other_____
medicines_____

Respiratory □ none
□ asthma
□ chronic obstructive pulmonary disease
□ emphysema
□ other_____
medicines_____
_____

Name of primary care medical doctor: