Grandville Optical – Patient Health Information

Name: ______________________________ Today's Date: ____________________________

Date of Birth: ________________________ Family Doctor: ___________________________

Medical History

Please list the names of any medications, prescribed or over-the counter, which you are currently taking: ____

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Please list any eye medications you are using, including over-the-counter drops:

____

Please list any drug allergies and the type of reaction you had:

____

Please list any major surgeries you have had, including the dates:

____

____

Family History

Please note any family members with the following conditions:

Blindness/Eye disease Yes_____ No_____ Relationship___________________

Glaucoma Yes_____ No_____ Relationship___________________

Macular Degeneration Yes_____ No_____ Relationship___________________

Lazy Eye Yes_____ No_____ Relationship___________________

Diabetes Yes_____ No_____ Relationship___________________

Social History

If you are employed, what is your occupation? ____

Do you use tobacco products? No_____ Yes_____ Quit _____years ago

Do you drink alcohol? None_____Socially_____2-3 times per week or more_____

Do you drive? No_____ Yes_____

Are you pregnant or nursing? No or Not Applicable_____ Yes_____ How many months_______

Review of Systems

Please indicate any health conditions you currently have or had in the past:

Allergy/Immunology

Allergies No_____ Yes_____ Explain_________________________________

Autoimmune Disease No_____ Yes_____ Explain_________________________________

Blood/Lymphatic

Anemia No_____ Yes_____ Explain_________________________________

Hepatitis No_____ Yes_____ Explain_________________________________

Clotting Disorder No_____ Yes_____ Explain_________________________________

Please continue on the back

Cardiovascular

Heart disease No_____ Yes_____ Explain_________________________________

High blood pressure No_____ Yes_____ Explain_________________________________

High cholesterol No_____ Yes_____ Explain_________________________________

Constitutional

Fever/chills No_____ Yes_____ Explain_________________________________

Weight loss	No_____	Yes_____	Explain________________________________
Endocrine			
Diabetes	No_____	Yes_____	Explain________________________________
Thyroid disease	No_____	Yes_____	Explain________________________________
Eyes			
Double vision	No_____	Yes_____	Explain________________________________
Eye injury	No_____	Yes_____	Explain________________________________
Lazy eye	No_____	Yes_____	Explain________________________________
Pain, discomfort	No_____	Yes_____	Explain________________________________
Ear, Nose, Throat			
Hearing loss	No_____	Yes_____	Explain________________________________
Sinus disease	No_____	Yes_____	Explain________________________________
Gastrointestinal			
Ulcers or Reflux	No_____	Yes_____	Explain________________________________
Hernia	No_____	Yes_____	Explain________________________________
Genitourinary			
Kidney disease	No_____	Yes_____	Explain________________________________
Urinary infections	No_____	Yes_____	Explain________________________________
Integumentary			
Keloids	No_____	Yes_____	Explain________________________________
Skin, nail problems	No_____	Yes_____	Explain________________________________
Musculoskeletal			
Arthritis	No_____	Yes_____	Explain________________________________
Joint replacement	No_____	Yes_____	Explain________________________________
Neurological			
Headaches	No_____	Yes_____	Explain________________________________
Multiple Sclerosis	No_____	Yes_____	Explain________________________________
Seizures	No_____	Yes_____	Explain________________________________
Stroke	No_____	Yes_____	Explain________________________________
Psychiatric			
Depression	No_____	Yes_____	Explain________________________________
Mood disorder	No_____	Yes_____	Explain________________________________
Respiratory			
Asthma	No_____	Yes_____	Explain________________________________
Emphysema	No_____	Yes_____	Explain________________________________

Any other medical conditions, including cancer and infectious diseases:

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Reviewed by: ______________________________ Date: ______________________________