24307 Harper
St. Clair Shores, MI
48080

Phone: 586-775-6733
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47093 Hayes
Shelby Township, MI
48315

Ph: 586-737-ISEE (4733)
Fax: 586-737-0716

36838 Ryan Road
Sterling Heights, MI
48310

Phone: 586-978-7232
Fax: 586-978-2745

137 S. Livernois Road
Rochester, MI 48307

Phone: 248-652-0600
Fax: 248-652-2661

Patient Health Information

Name: (*Last, First, M.I.*)	Birthdate	Today's Date

Thank you for taking your time to carefully complete the patient health information form. This information will be reviewed by the doctor during your examination. All information provided will be held in strict confidence.

PERSONAL MEDICAL/EYE HISTORY

Please note if you have any of the following conditions.

☐ None ☐ Diabetes ☐ High Cholesterol ☐ Macular Degeneration
☐ Cancer ☐ Arthritis ☐ Cataracts
☐ Heart Disease ☐ Dry Eye ☐ Lazy Eye
☐ High Blood Pressure ☐ Glaucoma ☐ Eye Injury
☐ Thyroid Disease ☐ Other ____________________

- List major injuries and surgeries you have had. ____________________
- List all medications you are currently taking (prescription and over-the-counter). ____________________
- Do you have any allergies to medications/Latex/Dyes? ☐ Yes ☐ No If yes, please list and describe reaction. ____________________
- Date of your last physical exam ____________ Are you pregnant / nursing? ☐ Yes ☐ No
- Have you had your eyes dilated? ☐ Yes ☐ No If yes, were there any problems? ____________
- Do you wear glasses? ☐ Yes ☐ No If yes, how old are your glasses? ____________
- Date of last complete eye exam ____________

FAMILY MEDICAL/EYE HISTORY

Please note any family members with the following conditions. Please also note on the line next to the condition how that person is related to you.

☐ None ☐ Diabetes ________ ☐ High Cholesterol________ ☐ Macular Degeneration________
☐ Cancer ________ ☐ Arthritis ________ ☐ Retinal disease________
☐ Heart Disease ________ ☐ Glaucoma ________ ☐ Lazy Eye ________
☐ High Blood Pressure________ ☐ Cataracts ________ ☐ Other________

PERSONAL SOCIAL HISTORY

- Please list your hobbies/recreational activities. ____________________
- Do you use an electronic device at work/home? ☐ Yes ☐ No If yes, how many hours/day?____________
- Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No
- Do you use tobacco products? ☐ Yes ☐ No ☐ Previously: If yes, amount/how long?____________
- Do you drink alcohol? ☐ Yes ☐ No If yes, how often?____________
- Do you use illegal drugs? ☐ Yes ☐ No If yes, how often?____________
- Birth Order ☐ First ☐ Second ☐ Third ☐ Fourth ☐ Fifth > more ☐ Twin
- Have you ever been infected with the following: HIV? ☐ Yes ☐ No TB? ☐ Yes ☐ No Hepatitis? ☐ Yes ☐

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REVIEW OF SYSTEMS

Please indicate below if you currently have or have in the last month, had any of the following health signs and symptoms:

Eyes

☐ None ☐ Blurred vision ☐ Burning ☐ Eye injury ☐ Light sensitivity/glare
☐ Loss of vision ☐ Dryness ☐ Eye pain ☐ Eye turn
☐ Redness ☐ Excessive tears ☐ Flashes/floaters ☐ Double vision
☐ Itching ☐ Tired/sore eyes ☐ Vision disturbance ☐ Other________________

Constitution

☐ None ☐ Fever ☐ Weight loss ☐ Chills ☐ Other________________

Cardiovascular

☐ None ☐ Chest pain ☐ Palpitations ☐ Lightheaded ☐ Other________________

Ear, Nose, Mouth, Throat

☐ None ☐ Hearing loss ☐ Sinus congestion ☐ Sore throat ☐ Other________________

Respiratory

☐ None ☐ Shortness of breath ☐ Pain when breathing ☐ Chronic cough ☐ Other________________

Gastrointestinal

☐ None ☐ Nausea ☐ Constipation ☐ Diarrhea ☐ Other________________

Genitourinary

☐ None ☐ Increased frequency ☐ Increased urgency ☐ Burning/itching ☐ Other________________

Muscles/Bones/Joints

☐ None ☐ Joint pain ☐ Joint swelling ☐ Restricted motion ☐ Other________________

Skin

☐ None ☐ Rashes ☐ Rosacea ☐ Sores ☐ Other________________

Neurological

☐ None ☐ Headaches ☐ Seizures or Convulsions ☐ Dizziness ☐ Other________________

Psychiatric

☐ None ☐ Anxiety ☐ Depression ☐ Memory loss ☐ Other________________

Endocrine

☐ None ☐ Frequent urination ☐ Elevated blood sugar ☐ Excessive thirst ☐ Other________________

Blood / Lymph

☐ None ☐ Bleeding disorder ☐ Swollen lymph nodes ☐ Low blood count ☐ Other________________

Allergic / Immunologic

☐ None ☐ Seasonal allergies ☐ Suppressed immune system ☐ Allergic rhinitis ☐ Other________________

Please explain any of the signs and symptoms that you checked above:

____

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