Welcome to the office of Robert M. Stern, M.D., Inc.

Health History Form

Patient Name: _____ **Date**: _____

Reason for Today's Visit: _____

Date of Last Eye Exam: _____ Name of Last Eye Doctor: _____

Name of any specialists you are currently seeing? Cardiology, Endocrinology, Rheumatology, Neurology _____

Do you wear glasses? Yes No ❒Always ❒Some ❒Reading ❒Driving ❒TV ❒Other:_____

Do your wear contacts currently? Yes No Type: _____Hrs/Day_____

Have you ever worn contacts? Yes No Problems: _____

Are you interested in wearing contacts? Yes No Are you interested in corrective laser surgery? Yes / No

SOCIAL HISTORY (CIRCLE ANSWER)

ALCOHOL USE	YES	NO _____	**DRIVE CURRENTLY**	YES	NO _____
ARE YOU PREGNANT	YES	NO _____	**WEIGHT LOSS/GAIN**	YES	NO _____
SMOKE CURRENTLY	YES	NO _____	**SMOKED IN PAST**	YES	NO _____

HEALTH HISTORY (CIRCLE ANSWER)

	YOURSELF		FAMILY MEMBER			YOURSELF		FAMILY MEMBER	
AIDS/HIV	YES	NO	YES	NO	**EMPHYSEMA**	YES	NO	YES	NO
ARTHRITIS	YES	NO	YES	NO	**HEART CONDITION**	YES	NO	YES	NO
BLEEDING	YES	NO	YES	NO	**HIGH BLOOD PRESSURE**	YES	NO	YES	NO
CANCER	YES	NO	YES	NO	**LUPUS**	YES	NO	YES	NO
CHRONIC ILLNESSES	YES	NO	YES	NO	**MIGRAINE/HEADACHES**	YES	NO	YES	NO
DIABETES	YES	NO	YES	NO	**STROKE**	YES	NO	YES	NO
DRUG					**THYROID CONDITION**	YES	NO	YES	NO
SENSITIVITY	YES	NO	YES	NO	**TUBERCULOSIS**	YES	NO	YES	NO

EYE HEALTH HISTORY (CIRCLE ANSWER)

	YOURSELF		FAMILY MEMBER			YOURSELF		FAMILY MEMBER	
BLINDNESS	YES	NO	YES	NO	**GLAUCOMA**	YES	NO	YES	NO
BLOODSHOT EYES	YES	NO	YES	NO	**HAY FEVER**	YES	NO	YES	NO
BLURRED-DISTANCE	YES	NO	YES	NO	**ITCHY EYE**	YES	NO	YES	NO
BLURRED-NEAR	YES	NO	YES	NO	**LAZY EYE**	YES	NO	YES	NO
BURNING EYES	YES	NO	YES	NO	**LIGHT SENSITIVE**	YES	NO	YES	NO
CATARACTS	YES	NO	YES	NO	**LOSS OF VISION**	YES	NO	YES	NO
CROSSED EYES	YES	NO	YES	NO	**MIGRAINE HEADACHES**	YES	NO	YES	NO
DOUBLE VISION	YES	NO	YES	NO	**NIGHT VISION-POOR**	YES	NO	YES	NO
EYE DISCHARGE	YES	NO	YES	NO	**POOR COLOR VISION**	YES	NO	YES	NO
EYE INFECTION	YES	NO	YES	NO	**RETINAL DISEASE**	YES	NO	YES	NO
INJURY	YES	NO	YES	NO	**SEEING HALOS**	YES	NO	YES	NO
EYE STRAIN	YES	NO	YES	NO	**TEMP VISION LOSS**	YES	NO	YES	NO
EYE SURGERY	YES	NO	YES	NO	**WATERING EYES**	YES	NO	YES	NO
FLOATERS/SPOTS	YES	NO	YES	NO	**OTHER**_____				

SURGICAL HISTORY

TYPE	DATE
_____	_____
_____	_____
_____	_____
_____	_____

EYE OPERATIONS

TYPE	DATE
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATION HISTORY (Please list any medications you are taking or have taken in the past year)

Name / Strength / How Often Taken/ How long on this medication	Name / Strength / How Often Taken/ How long on this medication
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGY HISTORY (Please list allergies to medications or other substances (environmental) and your reaction.)

_____

List any additional information on back side