

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 _____

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 _____

List any medicines you are allergic to:

Name of primary care medical doctor:

