MOLACEK family eyecare

Patients Name:_____ Date:_____

HEALTH HISTORY

Medical Physician's Name:_____ Date of last medical visit:_____

Please place a check on the line to indicate if you or a blood relative has had any of the following health conditions.

	You	Family
Cardiovascular Disease	____	____
Congestive Heart Disease	____	____
Elevated Cholesterol	____	____
Heart Murmur	____	____
Heart Palpitations	____	____
High Blood Pressure	____	____
Crohn's Disease	____	____
Diabetes	____	____
Thyroid Disorder	____	____
Acid-Reflex Syndrome	____	____
Alcoholism	____	____
Cancer: Colon	____	____
Cancer: Liver	____	____
Hepatitis	____	____
Kidney Stones	____	____
Prostate Cancer	____	____
Uterine Cancer	____	____
Anemia	____	____
Breast Carcinoma	____	____
Hodgkins Disease	____	____
Leukemia	____	____
Lymphatic Cancer	____	____

	You	Family
Aids	____	____
HIV Positive	____	____
Lyme Disease	____	____
Rheumatic Fever	____	____
Sjogren's Syndrome	____	____
Tuberculosis	____	____
Acne Rosacea	____	____
Lupus	____	____
Ocular Rosacea	____	____
Raynaud's Disease	____	____
Arthritis	____	____
Muscular Dystrophy	____	____
Osteoporosis	____	____
Scoliosis	____	____
Bell's Palsy	____	____
Brain Damage	____	____
Brain Tumor	____	____
Cerebral Palsy	____	____
Dyslexia	____	____
Epilepsy	____	____
Headaches(Migraine)	____	____
Multiple Sclerosis	____	____
Parkinson's Disease	____	____
Seizure Disorder	____	____

	You	Family
Anxiety Disorder	____	____
Autism	____	____
Bi-Polar Disorder	____	____
Dementia	____	____
Depression	____	____
Learning Disability	____	____
Schizophrenia	____	____
Asthma	____	____
exercise enduced	____	____
Cancer: Lung	____	____
COPD	____	____
Emphysema	____	____
Lung Disease	____	____
Cataracts	____	____
Glaucoma	____	____
Macular Deg.	____	____
Lazy /Turned Eye	____	____
Poor Color Vision	____	____
Retinopathy	____	____
Eye Surgery	____	____
Type: _____	Date:_____	

Other Health Conditions Not Listed Above:

_____

_____

Tobacco use ____Yes (__Cigarette or __Smokeless) ____No
Are you pregnant? ____ Number of Children ____
Alcohol use ____ Social ____1-2 per Day ____ Above Avg. ____ Dependent ____ None

MEDICATIONS / ALLERGIES

_____/_____

_____/_____

_____/_____

_____/_____