Patient Health History

The information in this confidential health history is critical to the evaluation of your vision and ocular health.

ATHENS EYE CARE
Dr. Shane Foster & Associates
A MEMBER OF VISION SOURCE®

Please note any health problems below:

Constitutional (cancer, developmental disabilities, etc) _____

Ears, Nose, Throat (hearing loss, sinusitis, etc) _____

Neurological (MS, migraine, vertigo/dizziness, etc) _____

Psychological (depression, bipolar, ADHD, etc) _____

Cardiovascular (blood pressure, heart disease, etc) _____

Respiratory (asthma, bronchitis, COPD, etc) _____

Gastrointestinal (acid reflux, Crohn's, ulcer, etc) _____

Genitourinary (kidney disease, prostate, menopause, etc) _____

Musculoskeletal (arthritis, osteoporosis, etc) _____

Dermatological (eczema, psoriasis, rosacea, etc) _____

Endocrine (diabetes, thyroid, etc) _____

Diabetes Doctor: _____ Year Diagnosed: _____

Last fasting blood sugar _____ Last A1C: _____

Hematological / Lymphatic (anemia, cholesterol, etc) _____

Allergy / Immunology (lupus, Sjogren's, etc) _____

Primary Care Physician: _____

Please list any medications you are currently taking: _____

_____

Allergies: _____

Height: _____ Weight: _____

Date of last eye exam: _____

Currently wear glasses?	YES	NO
Currently wear contact lenses?	YES	NO
Are you pregnant or nursing?	YES	NO
Do you use tobacco?	YES	NO
Amount: _____		
Do you drink alcohol?	YES	NO
Amount: _____		
Do you use other substances?	YES	NO
Amount: _____		

Please indicate if **you** or any of your **blood relatives** have a medical or ocular history in the following areas:

Cancer	Self	Mom	Dad	Brother	Sister
Diabetes	Self	Mom	Dad	Brother	Sister
Hypertension	Self	Mom	Dad	Brother	Sister
Thyroid	Self	Mom	Dad	Brother	Sister
Cataracts	Self	Mom	Dad	Brother	Sister
Glaucoma	Self	Mom	Dad	Brother	Sister
Macular Degeneration	Self	Mom	Dad	Brother	Sister
Dry Eye	Self	Mom	Dad	Brother	Sister
Lazy Eye	Self	Mom	Dad	Brother	Sister
Retinal Detachment	Self	Mom	Dad	Brother	Sister