Maryland Glaucoma and Eye Care **Health History Form**

Name:_____ **D.O.B:**_____ **Date:**_____

Past Medical History:

List Major Illnesses	List Major Surgeries and/or Injuries you have had

List any medications you currently are taking	

Allergies:_____

_____

Family History:
Does anyone in your family (blood relatives) have any eye conditions such as glaucoma, cataracts, crossed eyes, blindness? ___Yes ____No

_____

Does anyone in your family (blood relatives) have any medical conditions such as diabetes, heart disease, etc.? ___Yes ____No

_____

Social History:
Occupation:_____
Do you drive?__Yes __No Do you smoke?__Yes __No How Much?_____ Do you drink alcohol?__Yes __No How Much?_____

Review of Systems: Do you currently have any problems in the following areas? If yes, please explain below.

Yes	No		Yes	No		Yes	No		Yes	No	
		Fever			Lungs/Breathing			Skin Problems			Anxiety
		Weight Loss			Chronic Bronchitis			Neurological Conditions			Thyroid
		Sinus Problems			Stomach/Intestines			Headaches			Blood/Lymph Nodes
		Dry Mouth/Throat			Kidney/Bladder			Weakness			Seasonal Allergies
		Heart/Blood Vessels			Muscle/Joint Pain			Depression			Other

_____

_____

Other comments you want the Doctor to know:

_____

_____

Patient Signature:_____ **Doctor Signature:**_____

Maryland Glaucoma and Eye Care
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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Effective date July 20, 2015

I hereby acknowledge the Notice of Privacy Practices from Maryland Glaucoma and Eye Care, and have been offered a copy of the privacy practices.

_____
Today's date:

_____
Printed Name of Patient

_____
Signature of Patient, Guardian, or Legal Representative

_____
Relationship to patient (if signed by other than patient)