

Jeffries Eye Associates

Health / Surgical / Family History

Patient: _____

Date: _____

HEALTH CONDITIONS **NONE**

Explain / Comments

- Allergies _____
- Angina _____
- Anxiety _____
- Arthritis _____
- Asthma _____
- Atrial fibrillation _____
- Blood clots _____
- Cancer _____
- Cardiac arrhythmia _____
- COPD _____
- Coronary artery disease _____
- Crohn's disease _____
- Depression _____
- Diabetes
Type I x _____ yrs
Type II x _____ yrs
- High Cholesterol _____
- Gallbladder disease _____
- GERD _____
- Headache _____
- Heart disease _____
- Heart valve disorder _____
- Hepatitis/liver disease _____
- HIV + or AIDS _____
- Hypertension _____
- Irritable bowel disease _____
- LUPUS _____
- Multiple Sclerosis _____
- Myocardial infarction _____
- Osteoporosis _____
- Renal disease _____
- Seizure disorder _____
- Sjogren's disease _____
- Stroke _____
- Thyroid disease _____
- Other: _____

SURGICAL: **NONE** *Year*

- Angioplasty _____
- Arthroscopy Knee RT LT _____
Shoulder RT LT _____
- Back surgery _____
- Blood transfusion _____

SURGICAL: **NONE** *Year*

- CABG _____
- Cardiac pacemaker _____
- Cholecystectomy _____
- Colostomy _____
- Gastric bypass _____
- Hernia repair _____
- Hip replacement RT LT _____
- Hysterectomy _____
- Knee replacement RT LT _____
- Thyroidectomy _____
- Other: _____

FAMILY HISTORY: **NONE**

M=Mother, F=Father, S=Sister, B=Brother,
Son=Son, D=Daughter, O=Other

List How Related

- Amblyopia _____
- Arthritis _____
- Asthma _____
- Blindness _____
- Cancer _____
- Cardiovascular disease _____
- Cataracts _____
- Corneal disease _____
- Diabetes _____
- Glaucoma _____
- High Cholesterol _____
- Hypertension _____
- Macular degeneration _____
- Migraines _____
- Multiple sclerosis _____
- Renal disease _____
- Retinal disease _____
- Seizure disorder _____
- Strabismus _____
- Stroke _____
- Thyroid disorder _____
- Other: _____

X
SIGNATURE OF PATIENT (Guardian or Parent Signature, if minor)

Reviewed: _____