Hartzell Eye Specialists, LLC *featuring Optical Allusions*
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David Leigh Hartzell, MD
Ophthalmologist

HEALTH HISTORY

Welcome to our practice. As a new patient please fill out the information below to the best of your ability. To help us meet all of your healthcare needs, please fill out both sides of this form completely in ink. This is a confidential record of your medical history and will be kept in this office.

Patient Name _____ **Birthdate**____/____/____ **Date**____/____/____

Past Medical History

Have you ever had the following: (Check "Yes" or "No")

Yes	No		Yes	No		Yes	No	
___	___	Measles	___	___	Migraine Headaches	___	___	Hives or Eczema
___	___	Mumps	___	___	Tuberculosis	___	___	AIDS or HIV+
___	___	Chickenpox	___	___	Diabetes	___	___	Infectious Mono
___	___	Whooping Cough	___	___	Cancer	___	___	Bronchitis
___	___	Scarlet Fever	___	___	Polio	___	___	Stroke
___	___	Diphtheria	___	___	Glaucoma	___	___	Hepatitis
___	___	Smallpox	___	___	Hernia	___	___	Ulcer
___	___	Pneumonia	___	___	Blood/Plasma Transfusions	___	___	Kidney Disease
___	___	Rheumatic Fever	___	___	Back Trouble	___	___	Thyroid Disease
___	___	Heart Disease	___	___	High Blood Pressure	___	___	Bleeding Tendency
___	___	Arthritis	___	___	Low Blood Pressure	___	___	Epilepsy
___	___	Venereal Disease	___	___	Hemorrhoids	Any Other Disease (please list)		
___	___	Anemia	___	___	Asthma*	_____		
___	___	Bladder Infections	*Date of Last Chest X-ray_____			_____		

Previous Hospitalizations/Surgeries/Serious Illnesses	When	Hospital, City, State

Medications (Please list all medications you are currently taking):

Name	Dosage	Name	Dosage