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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies (Please list all foods, drugs, etc., that you are allergic to):

_____

_____

_____

_____

Patient Social History:

Use of Alcohol: Never_____ Rarely_____ Moderate_____ Daily_____
Use of Tobacco: Never_____ Previously, but quit_____ Currently (packs/day)_____
Use of Drugs: Never_____ Type/Frequency_____

Excessive Exposure at home to: Fumes_____ Dust_____ Solvents_____ Air-borne Particles: _____

Hobbies: _____
Exercise/Recreation: _____

Family Medical History:

Has any blood relative had any of the following: (please mark "yes" or "no")

___	___	Cancer	_____	___	___	Tuberculosis	_____
___	___	Diabetes	_____	___	___	Heart Disease	_____
___	___	High Blood Pressure	_____	___	___	Stroke	_____
___	___	Epilepsy	_____	___	___	Allergies	_____
___	___	Anemia	_____	___	___	Bleeding Tendency	_____
___	___	Asthma	_____	___	___	Chronic Lung Disease	_____
___	___	Mental Illness	_____	___	___	Leukemia	_____
___	___	Migraine Headaches	_____	___	___	Obesity	_____
___	___	Thyroid Disease	_____	___	___	Ulcer	_____
___	___	Depression	_____	___	___	High Cholesterol	_____
___	___	Kidney Disease	_____	___	___	Gout	_____
___	___	Glaucoma	_____	___	___	Cataracts	_____
___	___	Drug/Alcohol Problem	_____	___	___	Retinal Problems	_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

_____ _____
Signature of Patient/Parent/Guardian Date

Guardian's Relationship to Patient: _____

This Health History has been reviewed in its entirety with the patient.

_____ _____ _____
Signature of Professional Title Date