Brainerd Eyecare Center- General Health History

Name:_____ Date of Birth:_____ Date:_____

Please indicate any of the following system areas that you experience problems in and what associated medications you are taking:

Do you smoke? □ yes □ no

Allergy/Immune System □ **none**
□ drug allergy
□ seasonal allergy
□ rheumatoid arthritis
□ lupus
□ other_____
medicines_____

Cardiovascular □ **none**
□ heart disease
□ congestive heart failure
□ stroke
□ high cholesterol
□ high blood pressure
□ other _____
medicines_____
_____
_____

Constitutional/General □ **none**
□ weight change
□ developmental disability
□ cancer (type)_____
□ sleep apnea
□ other_____
medicines_____

Ears, Nose, Mouth, & Throat □ **none**
□ sinus problems
□ Sjogren's disease
□ other_____
medicines _____

Endocrine □ **none**
□ diabetes (how long_____)
□ hyperactive thyroid
□ underactive thyroid
□ Graves disease
□ hormone replacement
□ other
medicines_____

Gastrointestinal (stomach) □ **none**
□ Crohn's disease
□ colitis
□ ulcer
□ gastric esophageal reflux
□ other _____
medicines_____

List any medicines you are allergic to:

Genito-urinary □ **none**
□ prostate disease
□ kidney disease
□ other _____
medicines_____

Hematologic/Lymphatic □ **none**
□ anemia
□ bleeding problems
□ other_____
medicines_____

Skin Disease □ **none**
□ eczema
□ rosacea
□ other_____
medicines _____

Musculoskeletal □ **none**
□ fibromyalgia
□ osteoarthritis
□ gout
□ other _____
medicines _____
_____

Neurological □ **none**
□ multiple sclerosis
□ seizure disorder
□ Parkinson's disease
□ headaches other than occasional
□ other _____
medicines_____

Mental Health □ **none**
□ depression
□ bipolar disease
□ other_____
medicines_____

Respiratory □ **none**
□ asthma
□ chronic obstructive pulmonary disease
□ emphysema
□ other_____
medicines_____
_____

Name of primary care medical doctor: