WASHINGTON VITAL VISION

Personal Health Record

Name: _____ **Date form completed:** _____

Date of Birth: _____ **Height:** _____ **Weight:** _____

If the patient is 18 or younger: Were they born full term? ____; Birth Weight: _____; Any complications for baby? ____

Occupation/Work History: _____

Primary Care Physician (name and location if known): _____

Phone: _____ **Fax:** _____

Pharmacy Name: _____

Pharmacy Address: _____

Phone: _____ **Fax:** _____

PAST MEDICAL HISTORY

- ❑ Allergies (environmental/seasonal)
- ❑ Anemia [D64.9]
- ❑ Anxiety [F41.9]
- ❑ Arthritis [M19.9]
- ❑ Assisted living
- ❑ Asthma [J45.9]
- ❑ Atrial fibrillation [I48.91]
- ❑ Blood clots (DVT/PE) [D68.9]
- ❑ Cardiomyopathy
- ❑ COPD [J44.9]
- ❑ Cancer _____
- ❑ Coronary artery disease (CAD) [I25.9]
- ❑ Depression [F32.8]
- ❑ Diabetes
- ❑ Hepatitis C
- ❑ High cholesterol [E78.5]
- ❑ Heart Attack (MI) [I25.2]
- ❑ Heart failure/ congestive heart failure (CHF)
- ❑ Home O_2
- ❑ Hypertension, systemic [I10]
- ❑ Kidney disease [N18.9]
- ❑ Liver disease [K74.6]
- ❑ Migraine headaches [G43.009]
- ❑ "Mini" stroke (TIA)
- ❑ Morbid obesity (BMI >40)
- ❑ Seizure disorder [F44.5]
- ❑ Sleep apnea (OSA)
- ❑ Stroke (CVA) [G46.4]
- ❑ Thyroid disease
- ❑ Unmanaged acid reflux/ heartburn (GERD)
- ❑ Other: _____

SURGICAL HISTORY (Including Eye Surgery)

Name of Surgical Procedure	Date of Procedure	Reason for Surgical Procedure (if known)

Cardiac Stent(s): Date: _____

Chest Pain (past 6 months): _____

Heart Valve Disease: _____

Shortness of Breath (SOB): _____

Dialysis: _____

Active Infection: _____

Recent Surgery (within 2 weeks): _____

Pacemaker: _____

PLEASE COMPLETE BOTH SIDES OF THIS SHEET

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Name: _____ **Date form completed:** _____

FAMILY HISTORY ❑ Adopted (unknown history)

Disease	Dad	Mom	Brother	Sister	Daughter	Son	Other
Amblyopia (lazy eye)	❑	❑	❑	❑	❑	❑	❑
Cataracts	❑	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑	❑
Retinal Disease	❑	❑	❑	❑	❑	❑	❑
Strabismus (misalignment of eyes)	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑
Hypertension	❑	❑	❑	❑	❑	❑	❑
Other_____	❑	❑	❑	❑	❑	❑	❑

SOCIAL HISTORY

Tobacco Use: ❑ Current ❑ Past Smoker ❑ Never

❑ Cigarettes ❑ Cigar ❑ Chewing ❑ Other

Alcohol Use: How often/# of drinks a week _____

MEDICATIONS *Include prescription medications, over-the-counter medications (examples: aspirin, antacids), vitamins and herbal supplements (examples: ginseng, ginko)* ❑ Not currently taking any

Name of Medication	Dose (mg)	Frequency (i.e. daily, twice daily, every Friday, etc.)	Reason for taking this medication

ALLERGIES ❑ No Known Drug Allergies

Allergic To / Describe Reaction:	Allergic To / Describe Reaction:
	Are you allergic to latex? ❑ Yes ❑ No
	Are you allergic to iodine? ❑ Yes ❑ No

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