Patient Health Sheet

Newport Eye Center
1401 Avocado, Suite 505, Newport Beach, CA 92660 (949) 644-0239

Name:_____________________________________ Age:________ Weight:_______ Today's Date:_____________

Questions	No	Yes	Explanation
Physical disability?	❑	❑	
Disease/disorder of heart or blood vessels:			
High blood pressure?	❑	❑	
Coronary artery disease?	❑	❑	
Shortness of breath?	❑	❑	
Angina (chest pain) or heart attack?	❑	❑	
Carotid artery disease?	❑	❑	
Murmur?	❑	❑	
Disease/disorder of the nose, sinuses or throat?	❑	❑	
Disease/disorder of lungs or bronchi:			
TB?	❑	❑	
Chronic cough, asthma or emphysema?	❑	❑	
Disease/disorder of the esophagus or GI tract?	❑	❑	
Disease/disorder of the liver or gallbladder?	❑	❑	
Disease/disorder of the kidneys, ureters, bladder?	❑	❑	
Disease/disorder of the prostate or testicles?	❑	❑	
Disease/disorder of the breasts?	❑	❑	
Disease/disorder of the uterus, tubes or ovaries?	❑	❑	
Disease/disorder of the brain or nervous system?	❑	❑	
Severe headaches?	❑	❑	
Disease/disorder of the skin or lymph glands?	❑	❑	
Disease/disorder of the muscles, bones or joints?	❑	❑	
Arthritis?	❑	❑	
History of dentures?	❑	❑	
History of diabetes?	❑	❑	
History of tumor?	❑	❑	
History of venereal disease and treatment?	❑	❑	
Disease/disorder of the thyroid?	❑	❑	
Disease/disorder of the eyes:			
Glaucoma?	❑	❑	
Retinal problems?	❑	❑	
Cataracts?	❑	❑	
Use contact lenses (soft/hard/daily/exten)?	❑	❑	
Eye injuries?	❑	❑	
Hospitalizations or operations not indicated above?	❑	❑	
Exposure to harmful substances:			
Chemicals?	❑	❑	
Asbestos?	❑	❑	
Smoking (if yes, packs/day x years)?	❑	❑	
Weight gain or loss in past year?	❑	❑	
Military rejection/discharge for medical reasons?	❑	❑	
Used mind-altering drugs (if so amt. and freq.)?	❑	❑	
Allergies?	❑	❑	
Problems with anesthesia?	❑	❑	
Medications (name, amount, frequency)?	❑	❑	
Family history of (indicate relationship if yes):			
Diabetes?	❑	❑	
Stroke?	❑	❑	
Heart disease?	❑	❑	
High blood pressure?	❑	❑	
Cancer?	❑	❑	
Death before age 60?	❑	❑	
Glaucoma?	❑	❑	