

Ritter Hagee Optometry Established Patient History

Name: _____ DOB: _____

Occupation: _____ Email Address: _____

Gender: Male Female Preferred Language: _____

Race: Unknown American Indian or Atlantic Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander Other Race White

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Family Medical History

Please check if anyone in your immediate family (mother, father, brother or sister) has any of the following medical conditions:

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thyroid dysfunction |

Family Ocular History

Please check if anyone in your immediate family (parent, sibling or child) has any of the following eye conditions:

- | | |
|---|---|
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Severe Hyperopia | <input type="checkbox"/> Amblyopia |
| <input type="checkbox"/> Glaucoma Suspect | <input type="checkbox"/> Cataract |
| <input type="checkbox"/> Strabismus | <input type="checkbox"/> Dry Eyes |
| <input type="checkbox"/> Nystagmus | <input type="checkbox"/> Severe Myopia |
| <input type="checkbox"/> Glaucoma | |

Social History

Do you drink alcohol?

- | | |
|-----------------------------|---|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes: Drinks/day: _____ |
|-----------------------------|---|

Do you smoke?

- | | |
|--|--|
| <input type="checkbox"/> Never smoked | <input type="checkbox"/> Current every day smoker: |
| <input type="checkbox"/> Former smoker | packs/day: _____ |
| <input type="checkbox"/> Current some day smoker | |

Personal Medical History

Please check if you have any of the following medical conditions:

Constitution:

- Fatigue Syndrome
- Developmental Disabilities
- Cancer

Ear, Nose and Throat:

- Sinusitis
- Hearing Loss
- Laryngitis
- Dry Mouth

Neurological:

- Migraines
- Tumor
- Cerebral Palsy
- Multiple Sclerosis
- Stroke / CVA
- Epilepsy

Psychiatric:

- Anxiety Disorder
- Depression
- Bipolar Disorder
- Attention Deficit Disorder

Cardiovascular:

- Heart Disease
- Congestive Heart Failure
- Vascular Disease
- Stroke / CVA
- Hypertension

Respiratory:

- Emphysema
- Sleep Apnea
- Bronchitis
- Asthma
- Chronic Obstruction
- Cigarette Smoker

Gastrointestinal:

- Ulcer
- Celiac Disease
- Crohn's
- Acid Reflux
- Colitis

Genitourinary:

- Benign Prostate Hypertrophy
- Chlamydia
- Nursing
- Kidney Disease
- STD- Herpes/Chlamydia
- Pregnant

Musculoskeletal:

- Osteoarthritis
- Muscular Dystrophy
- Osteoporosis
- Arthritis
- Fibromyalgia
- Gout
- Ankylosing Spondylitis

Integumentary:

- Eczema
- Herpes Zoster/Shingles
- Rosacea
- Herpes Simplex/ Cold Sores
- Psoriasis

Endocrine:

- Thyroid dysfunction
- Type 1 Diabetes
- Type 2 Diabetes
- Hormonal Dysfunction

Hematologic/Lymphatic:

- Anemia
- Ulcer
- Large Volume Blood Loss
- Hypercholesteremia (elevated cholesterol)

Allergic/Immune

- Environmental Allergies
- Lupus
- Rheumatoid Arthritis
- Drug Allergies
- Sjogren's Syndrome

****Please list any other medical conditions that you may have that are not listed above:**

I have no medical conditions

Medications

Please list any medications (list dosages if possible) that you are currently taking: I take no medications

Please list any medications to which you are allergic: I have no medication allergies

Please list any other allergies that you may have: I have no other allergies
