Health History Update

Appointment Date: _____

Patient: _____ **Change in Address/phone number?** ❑ **Yes** ❑ **No**

If yes: _____

_____

Any changes in your health since your last visit? ❑ Yes ❑ No

If yes, does it include problems with any of these systems? Please check all applicable boxes.

❑ Gastrointestinal	❑ Nervous System	❑ Mental
❑ Ear/Nose/Throat	❑ Genitourinary	❑ Endocrine (Glands)
❑ Cardiovascular	❑ Musculoskeletal	❑ Blood/Lymph
❑ Respiratory	❑ Skin	❑ Allergic/Immunologic
❑ Headaches	❑ Surgeries (what type & when) _____	

Medications You Are Currently Taking:	**List Allergies to Medications or Other Substances:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are there any significant changes in your vision? ❑ Yes ❑ No

If yes, please check all applicable boxes.

❑ Dry Eyes	❑ Eye Surgeries	❑ Wear Glasses
❑ Blurred Vision	❑ Eye Injuries	❑ Wear Contacts

❑ Other, Please explain: _____

INSURANCE UPDATE: (If applicable, please provide a copy of your updated insurance card.)

❑ **My Primary Insurance is** _____**and I do not have any other insurance.**

❑ **My Primary Insurance is** _____,

and my Secondary Insurance is _____.

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

Signature: _____ **Date:** _____