Acct:

Health History, Part I

Name: _____ Date of Birth: _____ / _____ / _____

Street Address: _____ City: _____ Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Email: _____

Primary care doctor: _____

Emergency contact: _____

Phone ( )_____

Who referred you here? (Circle)

Doctor Family Friend

Web search Optical store

Insurance list Other:

Do any of your relatives see Dr. Seo?

If yes, name:

Allergies (to medicine, IV contrast): ☐ None

Medications: ☐ None

History of eye surgery, injury or lazy eye? (specify) ☐ None

List your medical diagnoses (e.g. diabetes, depression, hypertension, asthma): ☐ None

List your surgeries on any other part of the body (e.g. appendix, tonsils, cancer): ☐ None

Family history of eye problems? ☐ Unknown

	Yes	Relation to you
Amblyopia or "lazy" eye	☐	
Blindness	☐	
Crossed eyes	☐	
Glaucoma	☐	
Retinal detachment	☐	
Macular degeneration	☐	

	Yes	No	Quit
Smoking?	☐	☐	☐
Alcohol?	☐	☐	☐

Who lives at home with you?

Occupation:

(or, circle) none student retired

Former occupation:

Favorite Hobby:

(This space for office use only)

Acct:

Health History, Part II

Circle any that apply to you	None
Constitutional: Fevers, Weight loss, Headache Other:	☐
Ear, Nose, Throat: Hearing loss, Sinus problems Other:	☐
Cardiovascular: Chest pain, Irregular heart beats Other:	☐
Respiratory: Shortness of breath, Wheezing Other:	☐
Gastrointestinal: Abdominal pain, Nausea Other:	☐
Genitourinary: Blood in urine, Urinary pain Other:	☐
Musculoskeletal: Joint pains, Lower back pain Other:	☐
Skin: Rashes, Skin tumors Other:	☐
Neurological: Numbness, Weakness Other:	☐
Psychological: Anxiety, Depression Other:	☐
Endocrine: Heat intolerance, Thyroid problems Other:	☐
Hematological: Anemia, Unusual bleeding Other:	☐
Immunological: Hives, Seasonal allergies Other:	☐

If you circled a symptom, is your primary care physician aware? yes☐ no☐

The main reason for your appointment today?

_____

_____

_____

Anything else we may need to know?

_____

_____

_____