HARTZELL RUPP OPHTHALMOLOGY, P.C.

3 Baden Powell Lane, Suite 4, Mechanicsburg, PA 17050

HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the information below to the best of your ability. To help us meet all of your health care needs please fill out both sides of this form completely in ink. This is a confidential record of your medical history and will be kept in this office.

Patient Name: Date of Birth: / / Date: / /

Past Medical History: (Check "*Yes* " or "*No*")

	Yes	No		Yes	No		Yes	No
Measles			Heart Disease			Arthritis		
Mumps			Stroke			Hives or Eczema		
Rubella			Diabetes			Migraine Headaches		
Chickenpox			Cancer/ type:			Epilepsy		
Scarlet Fever			Hepatitis			Kidney Disease		
Diphtheria			Ulcer			Bladder Infections		
Smallpox			Hernia			Tuberculosis		
Rheumatic Fever			Hemorrhoids			Pneumonia		
Polio			High Blood Pressure			Asthma		
Infectious Mono			Low Blood Pressure			Chronic Bronchitis/COPD		
AIDS or HIV+			Blood or Plasma Transfusions			Any Other Diseases:		
Venereal Disease			Thyroid Disease					
Date of last EKG: / /			Date of last chest x-ray: / /					

Previous Hospitalizations/Surgeries/Serious Illnesses	**Date**	**Location**

Medications: (Please list all medications you are currently taking.)

Name	Dosage & Frequency	Name	Dosage & Frequency

Allergies: (Please list all food, drug, etc. that you are allergic to.)

Patient Social History:

Use of Alcohol: ❑ Never ❑ Rarely ❑ Moderately ❑ Daily

Use of Tobacco: ❑ Never ❑ Previously, but quit ❑ Currently (packs/day):

Use of Drugs: ❑ Never Type/Frequency:

Excessive Exposure at home for work to: ❑ Fumes ❑ Dust ❑ Solvents ❑ Air-borne Particles

Hobbies:

Exercise/Recreation:

Family Medical History:
Has any blood relative had any of the following? (Please check "*yes*" or "*no*")

Yes	No		Relationship	Yes	No		Relationship
		Cancer				Tuberculosis	
		Diabetes				Heart Disease	
		High Blood Pressure				Stroke	
		Epilepsy				Allergies	
		Anemia				Bleeding Tendency	
		Asthma				Chronic Lung Disease	
		Mental Illness				Leukemia	
		Migraine Headaches				Obesity	
		Thyroid Disease				Ulcer	
		Depression				High Cholesterol	
		Kidney Disease				Gout	
		Glaucoma				Cataracts	
		Drug or Alcohol Problem				Retinal Problems	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary healthcare services I (my child) need.

_____ _____

Signature of patient/Guardian *Date*