CHARLES W. STINE, O.D., P.C.
4 Pendleton Street, P.O. Box 1360
Middleburg, VA 20118
540-687-3634

Print Name _____

Health Information

Thank you for choosing us to provide you with eye care. As part of the eye care and to ensure greater health benefits, we need information about your health or any changes in your health that have occurred.

1. Please list your prescription medications: _____

_____

_____

2. Please list non-prescription medicine used recently: _____

_____

3. Are you allergic to any medications? _____ Latex gloves? _____ Other allergies? _____

If Yes, please list: _____

4. Please list all major operations and dates: _____

_____

Your History

If YES, *Circle* specific problem and check YES. If NO, check NO.

	YES	NO
Diabetes	❑	❑
Thyroid Condition	❑	❑
Heart Problem	❑	❑
High Blood Pressure	❑	❑
High Cholesterol	❑	❑
Cancer, Leukemia	❑	❑
Asthma, Bronchitis, Emphysema	❑	❑
Difficulty Breathing, Chest Pain	❑	❑
Persistent Cough, Bloody Sputum	❑	❑
Stomach, Liver, Intestinal Problems	❑	❑
Prostate, Ovarian, or Uterus Problems	❑	❑
Hearing, Taste, or Smell Problems	❑	❑
Arthritis, Lupus	❑	❑
Multiple Sclerosis	❑	❑
Seasonal Allergies	❑	❑
Headaches	❑	❑
Dizziness	❑	❑

	YES	NO
Night Sweats	❑	❑
Smoke, Drink Alcohol (more than 1/day)	❑	❑
Weight Loss, Poor Appetite	❑	❑
Fever	❑	❑

Other medical problems (please list):

_____

_____

Family History

Cataracts	❑	❑
Diabetes	❑	❑
Glaucoma	❑	❑
Heart Disease	❑	❑
Cancer	❑	❑

Patient Signature _____ Date _____

Updated _____ Date _____

Updated _____ Date _____

Updated _____ Date _____