



Affiliated Teaching  
Hospital of New York  
Medical College

**The New York Eye and Ear Infirmary**  
310 East 14th Street  
New York, NY 10003-4297  
Tel: 212 979 4000  
TTY: 212 979 4358

## CONFIDENTIAL PATIENT HEALTH HISTORY

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

<b>Medical History</b>		
<b>Check (✓) if you have or have had any of the following:</b>		
<input type="checkbox"/> Anemia	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> Headaches	<input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Problems: Describe:	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Back Problem	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Blood Disorders	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Cancer (Site):	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Swelling of feet or ankles
<input type="checkbox"/> Cough, Persistent	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Cough with Bloody Sputum	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tobacco/Cigarette Habit
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Drug Dependency:	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pace Maker	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Others:
<input type="checkbox"/> Fainting		
Have you had any serious illnesses or operations: <input type="checkbox"/> yes <input type="checkbox"/> No If yes, describe: _____		
Have you ever had a blood transfusion: <input type="checkbox"/> yes, date: _____ <input type="checkbox"/> No		
<b>Medications</b>	<b>Allergies</b>	
List medications you are currently taking:	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin
	<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Sulfa
	<input type="checkbox"/> Codeine	<input type="checkbox"/> Other
	<input type="checkbox"/> Local Anesthetic	
<b>Pharmacy Name:</b>	Describe reactions:	
<b>Phone Number:</b>		

The above information is accurate and complete to the best of my knowledge. I will not hold my physician or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Continuum Health Partners, Inc.

