IZAK HERSCHITZ, MD

LAST NAME:	FIRST NAME:	MALE ◯ FEMALE ◯ DOB:
ADDRESS:	CITY, ST, ZIP:	INSURANCE:
HOME TEL:	CELL #:	SS #:
EMERG. CONTACT:	TEL#:	EMAIL:
PHARMACY NAME/TEL/ADDRESS	HOW DID YOU HEAR ABOUT US?	PRIMARY CARE PHYSICIAN:

HEALTH HISTORY QUESTIONNAIRE

GENERAL HEALTH ISSUES	YES	NO
DIABETES		
HEART PROBLEMS / HEART SURGERIES / STENTS ETC.		
HIGH BLOOD PRESSURE		
ENDOCRINOLOGY / THYROID		
OTHER (please Print):		
EYE PROBLEMS		
FAMILY HISTORY OF CATARACT / GLAUCOMA / BLINDNESS / RETINA		
EYE SURGERIES / LASIK / LASER PROCEDURES		
GLASSES		
ALLERGIES		
BLURRY VISION		
DRY EYE SYMPTOMS		
OTHER-SPECIFY:		
SMOKING / ANY TOBACCO USE		

CURRENT LIST OF MEDICATIONS (Please Print):

_____

_____

_____ _____

Patient's Signature **Today's Date**