HAYDEN VISION

HEALTH HISTORY

Established Patient

NAME _____ **TODAY'S DATE** _____

SINCE YOUR LAST VISIT	YES	NO	IF YES, DESCRIBE
Any new medical conditions or surgeries?			
Any new medications or change in medication?			
Any new allergies?			
Any change in smoking status or alcohol use?			
Change in employment status?			

CHANGE IN OVERALL HEALTH	YES	NO		YES	NO
Fever			Active seasonal allergies		
Uncontrolled blood sugar			Arthritis flare-up		
Chest pain			Depression		
Shortness of breath requiring oxygen			Anxiety		
Chemotherapy or radiation treatments			COVID		