Albert Cytryn MD P.C

HEALTH HISTORY

Name of Patient: _____ **Date of Birth:** _____

Primary Care Physician: _____ Height: _____ Weight: _____

Please circle "Yes" or "No" to indicate if you have had any of the following:

Anemia	Yes	No	Arthritis	Yes	No
Asthma	Yes	No	Diabetes	Yes	No
Emphysema / COPD	Yes	No	Hypoglycemia	Yes	No
Bronchitis/ Chronic Cough	Yes	No	Thyroid Condition	Yes	No
Sleep Apnea	Yes	No	Cancer	Yes	No
If *yes*, do you have a CPAP?	Yes	No	Lupus	Yes	No
Tuberculosis	Yes	No	Lazy Eye	Yes	No
Hepatitis (Type__)	Yes	No	Poor Color Vision	Yes	No
Kidney Disease	Yes	No	Retinal Disease	Yes	No
High Blood Pressure	Yes	No	Blindness	Yes	No
Low Blood Pressure	Yes	No	Glaucoma	Yes	No
Heart Attack	Yes	No	Epilepsy/Seizues	Yes	No
Heart Faliure	Yes	No	Headaches/Migraines	Yes	No
Irregular Heartbeat	Yes	No	AIDS / HIV / STD'S	Yes	No
Heart Murmur	Yes	No	Shingles / Herpes	Yes	No
Pacemaker	Yes	No	Are you pregnant?	Yes	No
If yes, Do you have an ICD?	Yes	No	Breast feeding	Yes	No
Angina	Yes	No	Tobacco Use	Yes	No
Stroke	Yes	No	Alcohol Use?	Yes	No
Bleeding Tendencies	Yes	No	Recreational Drugs?	Yes	No
Blood Clots/Embolism	Yes	No	Wear Contact lenses?	Yes	No

If YES, How many drinks in a day___

Current Vaccination (with dates) Flu _____ Shingles_____ Pneumonia_____ Covid_____

ANY DISABILITIES or MEDICAL CONDITIONS? (If yes, please list) _____

MEDICATIONS: *Please list any medications you are currently taking including herbs, vitamins and eye drops.*

Pharmacy Name: _____ Phone: _____

ALLERGIES: _____

PRIOR SURGERIES: _____

SIGNATURE: _____ **DATE:** _____

All of the above information is correct / No changes _____ _____

MIP 22___ MIP 23___ MIP 24___ MIP 25__ MIP 26__ MIP 27___