Dr. Daniel J. Kosterman, OD
907-696-8733 (USEE)

11401 Old Glenn Hwy #105B
Eagle River, AK 99577

PATIENT HISTORY FORM

Name_________________________________ DOB___/___/_____ Exam Date___/___/_____

Please circle all applicable medical conditions.	Please list medications you take for this condition.
EYES - poor vision, eye pain, redness, dryness, glaucoma, cataracts, macular degeneration, other	
ALLERGIC/IMMUNOLOGIC – sneezing, swelling, itching, hives, lupus, seasonal/environmental allergies, rheumatoid arthritis, other	
CARDIOVASCULAR – high blood pressure, heart disease, vascular disease, stroke, other	
CONSTITUTION – fever, fatigue, weight gain/loss, trauma, other	
EAR/NOSE/MOUTH/THROAT – cold/cough, hearing loss, earache, dry mouth, other	
ENDOCRINE – hyperthyroid, hypothyroid, insulin dependent diabetes, non-insulin dependent diabetes, hormonal dysfunction, other	
GASTROINTESTINAL – ulcer, hernia, crohn's, colitis, digestive problems, acid reflux, other	
GENITOURINARY – std, impotence, jaundice, painful or frequent urination, other	
HEMATOLOGIC/LYMPHATIC – anemia, large volume blood loss, blood transfusion, leukemia, cholesterol, other	
SKIN – rosacea, eczema, psoriasis, rash, other	
MUSCULOSKELETAL – fibromyalgia, osteoarthritis, joint pain, swelling, joint replacement, other	
NEUROLOGICAL – MS, epilepsy, seizures, numbness, headaches, paralysis, other	
PSYCHIATRIC – depression, anxiety, insomnia, panic disorder, schizophrenia, other	
RESPIRATORY – asthma, bronchitis, emphysema, TB, other	

Has any member of your family been diagnosed with any of the following? Who?
Cataracts glaucoma macular degeneration diabetes hypertension heart disease

The information above is accurate and complete to the best of my knowledge.

Patient or Parent signature