HEALTH HISTORY FORM

NAME: _____DATE: _____

Describe in your own words why you are seeing us today. List any vision problems you are having:

_____

_____

_____

_____

EYE HISTORY – Have you been diagnosed with any of the following?

Yes	No		Yes	No	
☐	☐	Cataracts	☐	☐	Eye Injury
☐	☐	Corneal disease	☐	☐	Iritis
☐	☐	Crossed eyes/lazy eye	☐	☐	Retina disease
☐	☐	Glaucoma	☐	☐	Other eye disorders_____

Cataract Surgery (date of surgery) Right_____Left_____

Other eye surgery_____

MEDICAL HISTORY-Have you been diagnosed with any of the following?

Yes	No		Yes	No	
☐	☐	Asthma	☐	☐	Kidney disease
☐	☐	Cancer	☐	☐	Migraines
☐	☐	Carotid artery disease	☐	☐	Psychiatric/ nervous disorder
☐	☐	Diabetes__#of years	☐	☐	Rheumatoid arthritis
☐	☐	Head or spinal injuries	☐	☐	Seizures/convulsions/fainting
☐	☐	Heart disease	☐	☐	Stroke
☐	☐	High blood pressure	☐	☐	(Women) Are you pregnant?
☐	☐	HIV	☐	☐	Other_____

OTHER SURGICAL HISTORY

_____

_____

MEDICATIONS-List all medications (including eye drops) you are currently using (including dosage) _____

_____

_____

_____

ALLERGIES: Are you allergic to any medications? (Yes/No) If yes, please list them:

_____

_____

Please continue on the next page…..

FAMILY HISTORY (Has anyone in your family (blood relative) had any of the following in the past?) Please put a letter next to the appropriate box.

F-Father M-Mother P-Paternal ML-Maternal S-Sister B-Brother

Yes	No		Yes	No	
☐	☐	**Cataracts**	☐	☐	**Retinal detachment**
☐	☐	**Corneal disease**	☐	☐	**Other eye problems_____specify_____**
☐	☐	**Crossed eyes**	☐	☐	**Lazy eye**
☐	☐	**Diabetic retinopathy**	☐	☐	**Heart**
☐	☐	**Glaucoma**	☐	☐	**Stroke**
☐	☐	**Macular degeneration**	☐	☐	**Other_____**

Office Only:
Nurse/Tech signature_____Dr._____