

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
<input type="checkbox"/>	<input type="checkbox"/> Cataracts	<input type="checkbox"/>	<input type="checkbox"/> Eye Injury
<input type="checkbox"/>	<input type="checkbox"/> Corneal disease	<input type="checkbox"/>	<input type="checkbox"/> Iritis
<input type="checkbox"/>	<input type="checkbox"/> Crossed eyes/lazy eye	<input type="checkbox"/>	<input type="checkbox"/> Retina disease
<input type="checkbox"/>	<input type="checkbox"/> Glaucoma	<input type="checkbox"/>	<input type="checkbox"/> 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
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Kidney disease
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> Migraines
<input type="checkbox"/>	<input type="checkbox"/> Carotid artery disease	<input type="checkbox"/>	<input type="checkbox"/> Psychiatric/ nervous disorder
<input type="checkbox"/>	<input type="checkbox"/> Diabetes __#of years	<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/>	<input type="checkbox"/> Head or spinal injuries	<input type="checkbox"/>	<input type="checkbox"/> Seizures/convulsions/fainting
<input type="checkbox"/>	<input type="checkbox"/> Heart disease	<input type="checkbox"/>	<input type="checkbox"/> Stroke
<input type="checkbox"/>	<input type="checkbox"/> High blood pressure	<input type="checkbox"/>	<input type="checkbox"/> (Women) Are you pregnant?
<input type="checkbox"/>	<input type="checkbox"/> HIV	<input type="checkbox"/>	<input type="checkbox"/> 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 | |
|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Cataracts | <input type="checkbox"/> | <input type="checkbox"/> | Retinal detachment |
| <input type="checkbox"/> | <input type="checkbox"/> | Corneal disease | <input type="checkbox"/> | <input type="checkbox"/> | Other eye problems _____ specify _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Crossed eyes | <input type="checkbox"/> | <input type="checkbox"/> | Lazy eye |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetic retinopathy | <input type="checkbox"/> | <input type="checkbox"/> | Heart |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Macular degeneration | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

Office Only: Nurse/Tech signature _____ Dr. _____
