HEALTH HISTORY

Name: ____________________ **Date:** ____________

Please list any medical conditions you are being treated for. If "Yes", please explain.

Yes No

Cardiovascular (Heart, High Blood Pressure) ____________________
Respiratory (Asthma, Emphysema) ____________________
Gastrointestinal (Stomach, Ulcer) ____________________
Muscles, Bones, Joints (Arthritis) ____________________
Skin (Acne, Skin Cancer) ____________________
Neurological (Multiple Sclerosis, Headaches) ____________________
Psychiatric (Anxiety, Depression) ____________________
Endocrine (Diabetes, Hypothyroid) ____________________
Blood/Lymph (Anemia, HIV) ____________________
Allergic/Immunologic (Lupus, Hay Fever) ____________________
Other Diagnosed Health Issues ____________________

Please list all medications you are currently taking:

____

____

Please list all medications you are allergic to:

____

____

Ocular History – Have you been diagnosed with any of the following in the past?

Yes No

Cataracts ____________
Retina Disease ____________
Corneal Disease ____________
Glaucoma ____________

Yes No

Crossed Eyes ____________
Iritis ____________
Injury ____________
Other Eye Disorders ____________

Please list all surgeries (Cataract, Tonsillectomy, Appendectomy) and date of surgery:

____

____

Please list concerns about your eyes that you would like the Doctor to evaluate:

____

____

Family History – Relationship to Patient: M=Mother F=Father S=Sibling GP=Grandparent

Yes No

Macular Degeneration____________
Glaucoma ____________
Cataracts ____________
Corneal Disease ____________
Other Eye Disease ____________

Yes No

Diabetes ____________
Diabetic Retinopathy____________
Heart ____________
Cancer____________
Stroke ____________

Social History:

Yes No

Do you drink alcohol? How frequently? ____________________

HEALTH HISTORY

Do you smoke? How frequently? ______________________________

Have you taken any illegal substances within the last 12 months?

Physician's Signature: ______________________________ **Date:** ____________________