HEALTH HISTORY FORM

Patient Name: _____ **Date:** _____

Medical Doctor: _____ **Occupation / Hobbies:** _____

Your Eye History

Please check any of the following eye conditions which you have been diagnosed with at the present time or in the past.

- ☐ Glaucoma _____
- ☐ Cataracts _____
- ☐ Macular Degeneration _____
- ☐ Diabetic Retinopathy _____
- ☐ Corneal Disease _____
- ☐ Retinal Detachment _____
- ☐ Retinitis Pigmentosa _____
- ☐ Iritis / Uveitis _____
- ☐ Temporal Arteritis _____
- ☐ Crossed Eyes / Lazy Eye _____
- ☐ Eye Injury _____
- ☐ Contact Lens Wearer _____
- ☐ Other Eye Problems Not Listed _____

_____

Your Eye Surgeries

Please list any eye surgeries, injections, lasers or treatments you have had. Please include the eye treated and the date or year it was done.

Surgery: **Eye:** **Date:**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Your Eye Drops and Eye Medications

Please list any eye drops or eye medications you are using even if it is non-prescription. Please include the dosage. Please include eye vitamins.

☐ I do not currently take any eye drops, medications or vitamins

_____
_____
_____
_____
_____
_____
_____
_____

Your Medications

Please list any medications (not eye medications) that you are using even if it is non-prescription. Please include the dosage.

☐ I do not currently take any medications, vitamins or nutritional / herbal supplements

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Tech Signature: _____ **Initial Date:** _____

Doctor Signature: _____ **Initial Date**: _____

Date Reviewed: _____ Initials: _____
Date Reviewed: _____ Initials: _____
Date Reviewed: _____ Initials: _____
Date Reviewed: _____ Initials: _____
Date Reviewed: _____ Initials: _____
Date Reviewed: _____ Initials: _____
Date Reviewed: _____ Initials: _____
Date Reviewed: _____ Initials: _____
Date Reviewed: _____ Initials: _____
Date Reviewed: _____ Initials: _____

Date Reviewed: _____ Initials: _____
Date Reviewed: _____ Initials: _____
Date Reviewed: _____ Initials: _____
Date Reviewed: _____ Initials: _____
Date Reviewed: _____ Initials: _____
Date Reviewed: _____ Initials: _____
Date Reviewed: _____ Initials: _____
Date Reviewed: _____ Initials: _____
Date Reviewed: _____ Initials: _____
Date Reviewed: _____ Initials: _____

HEALTH HISTORY FORM – PAGE 2

Your Medical History

Please check any of the following conditions which you have been diagnosed with at the present time or in the past.

Cardiovascular
- ☐ High blood pressure _____
- ☐ High cholesterol _____
- ☐ Carotid Artery Disease _____
- ☐ Heart Attack _____
- ☐ Heart Disease _____
- ☐ Other: _____

Neurological
- ☐ Headaches ☐ Migraines _____
- ☐ Stroke _____
- ☐ MS _____
- ☐ Parkinson's ☐ Alzheimer's _____
- ☐ Developmental Delay _____
- ☐ Other: _____

Musculoskeletal
- ☐ Arthritis: ☐ Osteo ☐ Rheumatoid _____
- ☐ Other: _____

Immunologic
- ☐ Lupus _____
- ☐ HIV ☐ AIDS _____
- ☐ Other: _____

Ear, Nose, Throat, Mouth
- ☐ Sinus problems _____
- ☐ Dry mouth _____
- ☐ Seasonal Allergies _____
- ☐ Other: _____

Hematologic / Lymphatic
- ☐ Lymph Node Swelling _____
- ☐ Prostate _____
- ☐ Blood disorder _____
- ☐ Other: _____

Gastrointestinal
- ☐ Acid reflux/ GERD/ Ulcer _____
- ☐ Gallbladder _____
- ☐ Hepatitis _____
- ☐ Crohn's _____
- ☐ Other: _____

Genitourinary
- ☐ Bladder problems _____
- ☐ Kidney problems _____
- ☐ Other: _____

Constitutional
- ☐ Fever _____
- ☐ Change in weight / appetite _____
- ☐ Other: _____

Respiratory
- ☐ Chronic bronchitis ☐ Asthma _____
- ☐ Emphysema _____
- ☐ TB _____
- ☐ Other: _____

Other
- ☐ Cancer – Type _____
- ☐ Psychiatric Disorder _____
- ☐ Scarring Keloids _____

Endocrine
- ☐ Thyroid: ☐ Hypo ☐ Hyper
- ☐ Diabetes: ☐ Insulin ☐ Oral Meds ☐ Diet Controlled
  How long: _____
- ☐ Other: _____

Do You:
- ☐ Smoke? How much? _____
- ☐ Drink? How much? _____
- ☐ Use recreational drugs? _____
- ☐ Live alone? _____

Your Allergies

Please list any allergy to medications that you have and what happened when you took it.

_____
_____
_____
_____
_____

Your General Surgeries

Please list any surgical procedures you have had. Please include the approximate date it was done.

_____
_____
_____
_____
_____
_____
_____

Your Family History

Please list the family member who has any of the following conditions (mother, father, siblings etc.)

- ☐ Glaucoma _____
- ☐ Cataracts _____
- ☐ Macular Degeneration _____
- ☐ Corneal Disease _____
- ☐ Diabetic Retinopathy _____
- ☐ Retinal Detachment _____
- ☐ Crossed Eyes / Lazy Eye _____
- ☐ Other Eye Problems _____
- ☐ Diabetes _____
- ☐ Heart Conditions _____
- ☐ Stroke _____
- ☐ Other Health Problems _____

_____