

Patient Health History

Name: _____

Date: _____

GENERAL MEDICAL HISTORY (Have you been diagnosed with any of the following in the past?)

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure / Hypertension _____	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer _____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke _____	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid _____
<input type="checkbox"/>	<input type="checkbox"/>	Carotid Artery Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes: <input type="checkbox"/> IDDM <input type="checkbox"/> Type II # of yrs: _____	<input type="checkbox"/>	<input type="checkbox"/>	Temporal Arteritis _____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	HIV _____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	(Women) Are you pregnant? _____
<input type="checkbox"/>	<input type="checkbox"/>	Migraines _____	<input type="checkbox"/>	<input type="checkbox"/>	Nervous (Neurologic) Disorder _____
<input type="checkbox"/>	<input type="checkbox"/>	Head or Spinal Injuries _____	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Disorder _____
<input type="checkbox"/>	<input type="checkbox"/>	Seizures, Convulsions, Fainting _____	<input type="checkbox"/>	<input type="checkbox"/>	Extensive Confinement by Illness/ Injury: _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke? #yrs: _____ # packs/day: _____	<input type="checkbox"/>	<input type="checkbox"/>	Other(s): _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you taken any illegal substances in the last 12 months? _____			
<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcoholic beverages? How often: _____			

SURGICAL HISTORY (Please list all major surgeries)

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
_____	_____	_____	_____
_____	_____	_____	_____

MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING EYE DROPS):

MEDICATIONS YOU ARE ALLERGIC TO:

OCULAR HISTORY (Have you been diagnosed with any of the following in the past?)

YES	NO		YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts _____	<input type="checkbox"/>	<input type="checkbox"/>	Iritis _____	<input type="checkbox"/>	<input type="checkbox"/>	Injury: _____
<input type="checkbox"/>	<input type="checkbox"/>	Retina Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Cornea Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Other Eye Disorders: _____
<input type="checkbox"/>	<input type="checkbox"/>	Crossed Eyes _____	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear glasses or contact lenses? _____

Last Eye Exam Date: _____ Previous Eye Doctor(s): _____

Cataract Surgery Date(s): Right _____ Left _____ Do you have a Lens Implant? Yes No

Retina Surgery Date(s): Right _____ Left _____

Other Eye Surgery Date(s) & Type: _____

If YES for Eye Injury above, please explain: _____

FAMILY HISTORY (Has any blood-related member of your family had any of the following?)

Please note relationship to patient using: F – Father B – Brother GF – Grandfather U – Uncle P – Paternal
 M – Mother S – Sister GM – Grandmother A – Aunt M – Maternal

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment _____
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts _____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetic Retinopathy _____
<input type="checkbox"/>	<input type="checkbox"/>	Cornea Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes: <input type="checkbox"/> IDDM <input type="checkbox"/> Type II _____
<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration _____	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems _____
<input type="checkbox"/>	<input type="checkbox"/>	Retinitis Pigmentosa _____	<input type="checkbox"/>	<input type="checkbox"/>	Stroke _____
<input type="checkbox"/>	<input type="checkbox"/>	Other Eye Problem(s): _____	<input type="checkbox"/>	<input type="checkbox"/>	Other General Medical Problem(s): _____

Patient Signature: _____

Tech: _____