HEALTH HISTORY

Name______________________________ Date__________________

MEDICAL HISTORY

Have you ever been told you have the following?

YES	NO	
( )	( )	DIABETES: How long?_________________
( )	( )	HIGH BLOOD PRESSURE
( )	( )	HIGH CHOLESTEROL
( )	( )	CONGESTIVE HEART DISEASE
( )	( )	OTHER HEART DISEASE______________
( )	( )	ASTHMA
( )	( )	BRONCHITIS/EMPHYSEMA
( )	( )	SKIN DISORDER_____________________
( )	( )	KIDNEY DISEASE____________________
( )	( )	GASTROINTESTINAL DISEASE_________
( )	( )	LIVER DISEASE______________________
( )	( )	ARE YOU PREGNANT, OR PLAN TO BE?
( )	( )	DO YOU DRINK? How much?___________

YES	NO	
( )	( )	NEUROLOGICAL DISEASE_____________
( )	( )	NERVOUS DISORDER_________________
( )	( )	HEADACHE OR MIGRAINE
( )	( )	HEAD INJURY
( )	( )	STROKE
( )	( )	CANCER___________________________
( )	( )	ARTHRITIS: Rheumatoid?_______________
( )	( )	BLEEDING PROBLEM
( )	( )	DEPRESSION
( )	( )	HIV/AIDS
( )	( )	DO YOU SMOKE?
		How much?__________________________
( )	( )	USE DRUGS?

LIST MEDICATIONS YOU ARE CURRENTLY TAKING; INCLUDE VITAMINS/HERBS/OTC. LIST DOSAGES.
→ IF NONE, STATE NONE. LIST EYE MEDICATIONS.

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LIST ANY ALLERGY TO FOOD, MEDICATIONS OR DYE USED IN MEDICAL TESTING.
→ IF NONE, STATE NONE

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LIST ALL SURGERIES; INCLUDE DATES
→ IF NONE, STATE NONE

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FAMILY HISTORY [HAS ANYONE IN YOUR FAMILY(BLOOD RELATIVE) HAD ANY OF THE FOLLOWING?]

YES	NO	
( )	( )	GLAUCOMA_________________________
( )	( )	CATARACTS________________________
( )	( )	MACULAR DEGENERATION____________
( )	( )	DIABETES__________________________
( )	( )	RETINAL DETACHMENT______________
( )	( )	HEART CONDITIONS________________
( )	( )	OTHER EYE DISEASE_______________
( )	( )	OTHER GENERAL HEALTH PROBLEMS
		_________________________________
		_________________________________

YOUR EYE HISTORY

YES	NO	
( )	( )	CATARACTS
( )	( )	MACULAR DEGENERATION OR OTHER RETINAL DISEASE
( )	( )	GLAUCOMA
( )	( )	CROSSED OR LAZY EYE
( )	( )	OTHER EYE DISEASE_____________
		_______________________________
( )	( )	ANY EYE SURGERIES: LIST
		_______________________________
		_______________________________

If form filled out by anyone other than patient, please print your name

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