

HEALTH HISTORY

Name _____

Date _____

MEDICAL HISTORY *Check all that apply*

Diabetes:

- None
- Pre-diabetic
- Type I or juvenile-onset diabetes
- Type II or adult-onset diabetes
- Gestational Diabetes
- Blood sugar level _____
- Hemoglobin A1c level _____

Stroke:

- None (skip to next category)
- If yes, how many? _____
- Mini-stroke or TIA
- Right-sided weakness
- Left-sided weakness
- Vision damage from stroke
- Aneurysm

Kidney disease:

- None
- Diabetic nephropathy
- Kidney stones
- Kidney failure
- Polycystic kidney disease
- Kidney transplant
- On dialysis
- Only have one kidney

Heart disease:

- None
- Angina or chest pain
- Arrhythmia or irregular heart beat
- Atrial fibrillation
- Angioplasty surgery
- Enlarged heart
- Coronary artery disease
- Myocardial infarction or heart attack
- Heart bypass surgery
- Congestive heart disease
- Defibrillator
- Pacemaker
- Valve replacement surgery

Hypertension (high blood pressure):

- None
- Yes, well-controlled
- Yes, poorly-controlled

Asthma:

- None
- Yes
- Childhood asthma

Lung disease:

- None
- Bronchitis
- Cancer
- COPD
- Emphysema
- Pneumonia
- Pulmonary embolus
- Sarcoidosis
- TB or tuberculosis

Other:

- No other medical problems
- Depression
- Alzheimer's disease
- Parkinson's disease
- Thyroid problems
- Lupus
- Prostate problems
- Developmental delay
- Difficulty hearing
- Cancer
- Arthritis: Rheumatoid? _____
- Other problems? Please explain

CONTINUED ON BACK SIDE

Other medical history:

- Occupation _____
- Retired _____
- Hobbies: _____
- Drink alcohol. If so, how much? _____
- Smoke. If so, how much and how long? _____
- Quit smoking. If so, how long ago? _____
- Second-hand smoke exposure _____
- Drug use. What kind? _____
- Pregnant _____
- Nursing _____

Medications (including eye drops):

Surgeries:

Allergies:

EYE HISTORY

Surgery:

- None
- If yes, what have you had? _____
- _____
- _____
- _____

Eye trauma:

- None
- If yes, what kind? _____
- _____
- _____
- _____

Retinal problems:

- None
- Retinal detachment
- Retinal tear
- Retinal laser treatment
- Diabetic retinopathy

Glaucoma:

- None
- Yes
- Glaucoma suspect
- History of increased eye pressure

FAMILY HISTORY

- Any family history of diabetes?
- Any family history of high blood pressure?
- Any family history of stroke?
- Any family history of retinal problems?
- Any family history of glaucoma?
- Any family history of blindness?
- Any family history of heart problems?
- Any other family history? _____

If this form was filled out by anyone other than the patient, please print your name and relationship to the patient. Name: _____ Relationship: _____