Medical History

(Please print the following information)

Name ______________________________ Date of Birth ______________ DATE ______________

Address ______________________________ Apt/Unit # __________ Home Tel # ______________

City ______________________________ State ______ Zip __________ Work Tel # ______________

Who is your primary care doctor ______________________________ Your Cell Tel # ______________

In an emergency, please contact ____

Relationship ______________ Home # ______________ Work # ______________ Cell # ______________

If you were referred by a physician, please list name: ______________________________

Please List All Allergies: ____

____ ❑ I have no known allergies

Yes	No		Yes	No	
☐	☐	Lung Disease: Asthma__TB__Other______________	☐	☐	Head or Spinal Injuries ______________
☐	☐	Kidney Disease-Type:______________	☐	☐	Seizures, Convulsions, Tremors, or Fainting __________
☐	☐	Arthritis-Type: Osteo____Rheumatoid____	☐	☐	Temporal Arteritis______________
☐	☐	Diabetes: Diet ______ Insulin _____ # of yrs ________	☐	☐	Carotid Artery-Disease ______________
☐	☐	Thyroid Disease-Type: Hyper____Hypo____	☐	☐	Hormone Replacement ______________
☐	☐	Neurological Disease______________	☐	☐	(Women) Are you pregnant or nursing?__________
☐	☐	Headaches or Migraines ______________	☐	☐	Immune System Disorders: Leukemia___Lupus___ HIV___AIDS__MRSA ______________
☐	☐	Psychiatric Disorder ______________			
☐	☐	Cancer-Type:______________	☐	☐	Stroke______________
☐	☐	Any Central Nervous System Disorders ______________	☐	☐	Any Other Disease/ Disorder/ Injury Not Listed: ______________
☐	☐	Heart Disease ______________			
☐	☐	Cardiovascular: Heart Attack___Angina___Other______	☐	☐	Recent Fever______________
☐	☐	Blood Disorder: Anemia__Bruising/Bleeding__Other___	☐	☐	Recent Change in Weight____Change in Appetite____
☐	☐	G.I. Disorder: Ulcer__Gallbladder__Hepatitis__Other__	☐	☐	Do You Use Recreational Drugs?______________
☐	☐	Seasonal Allergies_____Sinus Problems_____	☐	☐	Do You Smoke?______Packs Per Day___Week___
☐	☐	High Blood Pressure ______________# of yrs_____	☐	☐	Do You Drink? #___ Per Day___Week___Month___
☐	☐	Any Ear, Nose or Throat Disorders ______________	☐	☐	Do You Live Alone?______________

Please List All Medications & Vitamins You Are Currently Taking

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

<u>Surgical History</u> (Please Include Date and Type)

____

____

____ (Continue History On Back of Sheet)

Any changes in your daily living activities due to visual changes?

Watching TV ________ Reading ________ Tennis ________
Seeing street signs ________ Computer ________ Golf ________
Night driving ________ Sewing ________ Other ____________________

When was your last eye exam? ______________________

Do you wear glasses? Yes ___ No ___ Wear contact lenses? Yes ___ No ___

List any eyedrops you are currently using:

Name ____________________________________ How often? ____________________________
Name ____________________________________ How often? ____________________________
Name ____________________________________ How often? ____________________________

Who was your previous eye doctor? ____

Your Eye History (Have you been diagnosed with any of the following conditions in the past?)

Yes	No	Condition	Yes	No	Condition
☐	☐	Cataracts ______________	☐	☐	Corneal Disease ______________
☐	☐	Retinal Disease ______________	☐	☐	Glaucoma ______________
☐	☐	Crossed Eyes ______________	☐	☐	Eye Injury ______________
☐	☐	Iritis or Inflammation Inside of the Eye ______________	☐	☐	Any Other Eye Disorders: ______________

Cataract Surgery (Date of Surgery) Right Eye ____________________ Left Eye ____________________

Did you have a lens implanted during Cataract Surgery? Yes ☐ No ☐

Other Surgery & Date of Surgery: Right Eye ____________________ Left Eye ____________________
Right Eye ____________________ Left Eye ____________________

Family History: (Note Relation To Patient Using Abbreviations: F=Father M=Mother P=Paternal M=Maternal S=Sister B=Brother GF=Grandfather GM=Grandmother U=Uncle A=Aunt

Yes	No	Condition	Yes	No	Condition
☐	☐	Glaucoma ______________	☐	☐	Retinal Detachment ______________
☐	☐	Cataracts ______________	☐	☐	Other Eye Problems ______________
☐	☐	Corneal Disease ______________	☐	☐	Diabetes ______________
☐	☐	Macular Degeneration ______________	☐	☐	Heart Conditions ______________
☐	☐	Retinitis Pigmentosa ______________	☐	☐	Stroke ______________
☐	☐	Diabetic Retinopathy ______________	☐	☐	Other General Health Problems: ______________

PATIENT SIGNATURE ____

Tech Signature: ________________________________ **Initial Review Date** ________________

Doctor Signature: ________________________________ **Initial Review Date** ________________

Date Reviewed & Updated ____________ **Tech Signature** ____________
Date Reviewed & Updated ____________ **Tech Signature** ____________
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A NEW HEALTH HISTORY FORM SHOULD BE COMPLETED ANNUALLY.