

HEALTH HISTORY FORM

Name: _____ **Date:** _____

Describe in your own words why you are seeing us today. Please list any vision problems you are having:

IS THIS RELATED TO AN EYE INJURY? _____ **YES** _____ **NO**

ALLERGIES: Are you allergic to any medications? (Yes/No) If yes, please list them:

MEDICATIONS: List all medications (including eye drops) you are currently using:

EYE HISTORY- Have you been diagnosed with any of the following?

<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>	
[]	[]	Retinal Detachment	[]	[]	Cataracts
[]	[]	Macular Degeneration	[]	[]	Glaucoma
[]	[]	Iritis	[]	[]	Eye Injury
[]	[]	Diabetic Retinopathy	[]	[]	Vitreous Hemorrhage

Cataract surgery (date of surgery) Right _____ Left _____

Other eye surgery (please include dates) _____

MEDICAL HISTORY- Have you been diagnosed with any of the following?

[]	Asthma	[]	Kidney Disease
[]	Cancer	[]	Migraines
[]	Carotid artery disease	[]	Thyroid Disease
[]	Diabetes ___# of years	[]	Rheumatoid arthritis
[]	Head or spinal injury	[]	(Women) Are you pregnant?
[]	Heart disease	[]	Anemia
[]	High Blood Pressure	[]	Other:_____

Please continue on the next page...

PLEASE LIST ALL OTHER SURGERIES:

SOCIAL HISTORY:

Do you smoke? Yes or No Do you currently drink Alcohol? Yes or No
 Do you currently drive? Yes or No. Do you have any restrictions? _____

FAMILY HISTORY Has anyone in your family (blood relative) had any of the following? Please put a letter next to the appropriate box.

F- Father **M**- Mother **S**-Sister **B**-Brother **A**-Aunt **U**-Uncle
MGM- Maternal Grandmother **PGM**- Paternal Grandmother
MGF- Maternal Grandfather **PGF**- Paternal Grandfather

<input type="checkbox"/>	<input type="checkbox"/>	Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration
<input type="checkbox"/>	<input type="checkbox"/>	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Diabetic Retinopathy	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

 Signature of Patient or Guardian

 Date