HEALTH HISTORY

Date_____

Patient Name_____

Date of Birth_____

Chart#_____

Primary Care Physician_____

MEDICAL HISTORY Have you been diagnosed with any of the following conditions in the past?

Yes No

☐ ☐ Diabetes: NIDDM____IDDM____
# of years____Followed by DR._____
☐ ☐ Thyroid Disease: HYPER____HYPO____
☐ ☐ Lung Disease: Asthma____TB____COPD____
☐ ☐ High Blood Pressure: #of years_____
☐ ☐ Heart Disease: Angina____Heart Attack____
Date(s)_____Stent(s)_____
☐ ☐ Stroke: Date(s)_____
☐ ☐ Blood disorder: Anemia___Bruising/Bleeding__
☐ ☐ Carotid Artery Disease_____
☐ ☐ Temporal Arteritis_____
☐ ☐ Neurological Disease_____
☐ ☐ Psychiatric Disorder_____
☐ ☐ Cancer: Type_____Date(s)_____
Treatment(s)_____
☐ ☐ Autoimmune Disease: HIV__AIDS__Other____
☐ ☐ Headaches____Migraines___and Frequency____
☐ ☐ Seasonal Allergies_____Sinus Problems_____
☐ ☐ (Women) Currently: Pregnant____Nursing____
☐ ☐ Do you drink alcohol? Glasses per day_____
☐ ☐ Do you smoke? _____per day

YOUR EYE HISTORY Have you been diagnosed with any of the following conditions in the past. Please include dates of diagnosis and any pertinent information

Yes No

☐ ☐ Cataracts_____
☐ ☐ Cataract Surgery: date(s) Right_____Left_____
☐ ☐ Retinal Disease_____
☐ ☐ Crossed Eyes_____
☐ ☐ Iritis or inflammation inside of the eye_____
☐ ☐ Corneal Disease_____
☐ ☐ Glaucoma_____
☐ ☐ Eye Injury_____
☐ ☐ Any other eye disorders_____
☐ ☐ Other eye surgeries_____

_____

FAMILY HISTORY Has anyone in your family (blood relative) had any of the following? Please include relation of family member.

Yes No

☐ ☐ Corneal Disease_____
☐ ☐ Macular Degeneration_____
☐ ☐ Glaucoma_____

MEDICATIONS YOU ARE TAKING

Please include non-prescriptive medications.

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DRUG ALLERGIES

_____
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UPDATED

Patient Initials_____Date_____
Physician Initials_____Date_____

Patient Initials_____Date_____
Physician Initials_____Date_____

Patient Initials_____Date_____
Physician Initials_____Date_____

Patient Initials_____Date_____
Physician Initials_____Date_____

Patient Initials_____Date_____
Physician Initials_____Date_____