HEALTH HISTORY FORM

NAME: _____ **D.O.B:** _____

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

_____

_____

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

Yes	No		Yes	No	
☐	☐	Cataracts	☐	☐	Eye Injury
☐	☐	Corneal disease	☐	☐	Iritis
☐	☐	Crossed eyes/lazy eye	☐	☐	Retina disease
☐	☐	Glaucoma	☐	☐	Other eye disorders_____

Cataract Surgery (Date of surgery) Right_____ Left_____
Other eye surgery_____

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

Yes	No		Yes	No	
☐	☐	Asthma	☐	☐	Kidney disease
☐	☐	Cancer	☐	☐	Migraines
☐	☐	Carotid artery disease	☐	☐	Psychiatric/ nervous disorder
☐	☐	Diabetes - #of years _____	☐	☐	Rheumatoid arthritis
☐	☐	Head or spinal injuries	☐	☐	Seizures/convulsions/fainting
☐	☐	Heart disease	☐	☐	Stroke
☐	☐	High blood pressure	☐	☐	(Women) Are you pregnant?
☐	☐	HIV	☐	☐	Other_____

OTHER SURGICAL HISTORY _____
_____

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

_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES: Are you allergic to any medications? Yes No. If yes, please list them:
_____
_____

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

F - Father M - Mother P - Paternal ML - Maternal S - Sister B - Brother

Yes	No		Yes	No	
☐	☐	Cataracts	☐	☐	Retinal detachment
☐	☐	Corneal disease	☐	☐	Other eye problems - specify_____
☐	☐	Crossed eyes	☐	☐	Lazy eye
☐	☐	Diabetic retinopathy	☐	☐	Heart
☐	☐	Glaucoma	☐	☐	Stroke
☐	☐	Macular degeneration	☐	☐	Other_____

The above information is correct and current. Initials _____ Date_____ Tech initials_____
Initials _____ Date_____ Tech initials_____