HEALTH HISTORY

PATIENT NAME ______________________ **DATE** ______________

Your Medical Doctor ______________________

Occupation & Hobbies ______________________

Yes	No	Condition
☐	☐	Lung Disease: Asthma ____ TB ____ Other _______
☐	☐	Kidney Disease-Type: ______________
☐	☐	Arthritis-Type: Osteo______Rheumatoid ________
☐	☐	Diabetes: # of years ________ Insulin: YES NO
☐	☐	Thyroid Disease-Type: Hyper ______ Hypo ______
☐	☐	Neurologic Disease ______________
☐	☐	Headaches or Migraines ______________
☐	☐	Psychiatric Disorder ______________
☐	☐	Cancer-Type ______________
☐	☐	Any Central Nervous System Disorders __________
☐	☐	Heart Disease ______________
☐	☐	Cardiovascular: Heart Attack ______ Angina ______
☐	☐	High Cholesterol ______________
☐	☐	Blood Disorder: Anemia ___ Bruising/Bleeding______
☐	☐	GI Disorder: Ulcer ___ Gallbladder ___ Hepatitis ___
☐	☐	Seasonal Allergies ___ Sinus Problems ________
☐	☐	High Blood Pressure: # of years ______________
☐	☐	Scarring Keloids ______________
☐	☐	Any Ear, Nose or Throat Disorders ______________

Yes	No	Condition
☐	☐	Head or Spinal Injuries ______________
☐	☐	Seizures, Convulsions, Tremors or Fainting________
☐	☐	Temporal Arteritis______________
☐	☐	Carotid Artery Disease ______________
☐	☐	Hormone Replacement ______________
☐	☐	(Women) Are you pregnant or nursing?__________
☐	☐	Lymph Node Swelling______________
☐	☐	Immune System Disorders: Leukemia ___ Lupus ___ HIV_____ AIDS ______ Other __________
☐	☐	Stroke ______________
☐	☐	Gout ______________
☐	☐	Any Other Disease / Disorder / Injury Not Previously Listed ______________
☐	☐	Recent Fever ______________
☐	☐	Recent Change in Weight __ Change in Appetite ___
☐	☐	Do You Use Recreational Drugs?__________
☐	☐	Do You Smoke # __Packs/Day __ Week __ Month __
☐	☐	Do You Drink # ___ Per Day __ Week __ Month __

Who lives in the house with you? ______________

Please List ALL Medications, Vitamins & Nutritional/ Herbal Supplements You Are Currently Taking:

☐ I do not currently take any medications, vitamins, or nutritional/herbal supplements.

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Please List All Medication Allergies & Other Known Allergies (Describe Type of Reaction)

☐ I do not have any known allergies to medications.

☐ I do not have any other known allergies (food, pollen, etc).

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__Your Eye History__ (Have you been diagnosed with any of the following in the past?)

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

Cataract Surgery (Date of Surgery) Right ______________ Left ______________

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

Other Eye Surgery & Date of Surgery Right ______________ Left ______________

Right ______________ Left ______________

(Continue History On Back of Sheet)

HEALTH HISTORY

PATIENT NAME ______________________________ **DATE** ____________________

Family History **Has anyone in your family (blood relative) had any of the following?**

NOTE RELATION TO PATIENT USING ABBREVIATION: F=Father M=Mother P=Paternal M=Maternal S=Sister B=Brother GF=Grandfather GM=Grandmotl U=Uncle A=Aunt

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

Surgical History **(Please Include Date and Type)**

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Initial Review Date ____________ **Tech Signature:** ____________

Date Reviewed & Updated		Tech Signature	
Date Reviewed & Updated	____________	Tech Signature	____________
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Annual Review & Update by Patient

Date Reviewed & Updated		Patient Signature	
Date Reviewed & Updated	____________	Patient Signature	____________
Date Reviewed & Updated	____________	Patient Signature	____________
Date Reviewed & Updated	____________	Patient Signature	____________

(Continue History On Back of Sheet)