HEALTH HISTORY

PATIENT NAME_____ DATE _____

Your Medical Doctor_____ Occupation _____

Yes	No	
☐	☐	Lung Disease: Asthma___TB___Other_____
☐	☐	Kidney Disease—Type: _____
☐	☐	Arthritis—Type: ___Osteo ___ Rheumatoid
☐	☐	Diabetes: NIDDM ___ IDDM ___ # of Years ____
☐	☐	Thyroid Disease—Type: Hyper ___ Hypo ___
☐	☐	Neurological Disease _____
☐	☐	Headaches or Migraines _____
☐	☐	Psychiatric Disorder _____
☐	☐	Cancer—Type: _____
☐	☐	Heart Disease _____
☐	☐	Blood Disorder: Anemia___ Other _____
☐	☐	G.I. Disorder: Ulcer ___ Hepatitis ___ Other ___
☐	☐	Seasonal Allergies ____ Sinus Problems _____
☐	☐	High Blood Pressure _____ # of yrs _____
☐	☐	Any Ear, Nose or Throat Disorders _____
☐	☐	Do you use cigarette/tobacco?

Yes	No	
☐	☐	Head or Spinal Injuries_____
☐	☐	Seizure, Convulsions, Tremors, or Fainting _____
☐	☐	Temporal Arteritis _____
☐	☐	Carotid Artery Disease _____
☐	☐	Hormone Replacement _____
☐	☐	(Women) Are you pregnant or Nursing? _____
☐	☐	Immune System Disorders: Leukemia ___ Lupus ___ HIV ___ AIDS ___ Other _____
☐	☐	Stroke _____
☐	☐	Cardiovascular: Heart Attack ___ Other _____
☐	☐	Any Other Disease/Disorder/Injury Not Listed: _____ _____
☐	☐	Recent Change in Weight ___ Change in Appetite ___
☐	☐	Do you use Recreational Drugs?
☐	☐	Do You Drink? # ___Per Day ___ Week ____Month

Please List All Medications, Vitamins, Nutrition/Herbal Supplements You Are Currently Taking:	Please List All Medication & Other Known Allergies
☐ **I do not currently take any Medications, Vitamins or Nutritional/Herbal Supplements.**	☐ **I do not have any known Allergies to Medications** ☐ **I do not have any other known allergies (foods, pollens, etc.)**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

Yes	No	
☐	☐	Cataracts_____ Surgery Date _____
☐	☐	Retinal Disease_____
☐	☐	Strabismus (Crossed Eyes)_____
☐	☐	Eye Injury_____
☐	☐	Macular Degeneration_____
☐	☐	Do You Wear Glasses Now? ___Full time ___Part time
☐	☐	Are You Interested in Lasik (Refractive Surgery)?

Yes	No	
☐	☐	Corneal Disease_____
☐	☐	Glaucoma_____
☐	☐	Amblyopia (Lazy Eye)_____
☐	☐	Iritis or Inflammation Inside the Eye_____
☐	☐	Any Other Eye Disorder_____
☐	☐	Do You Wear Contact Lenses? Type-_____
☐	☐	Are You Interested in Contact Lenses?_____

Check the visual symptoms you currently experience: (while wearing correction if glasses or contacts have been prescribed)

_____ Red Eyes	_____ Double Vision	_____ Unusual Blinking	_____ Glare sensitivity
_____ Itchy Eyes	_____ Dizziness	_____ Eye Strain	_____ Tendency to Close One Eye
_____ Watery Eyes	_____ Burning	_____ Light Sensitivity	_____ Eye turn (in or out)
_____ Soreness	_____ Crusted Eyelids	_____ Other	_____ Get Sleepy When Reading
_____ Mucus Discharge	_____ Gritty Sensation	_____ Headache	_____ Reread or Omit Words
_____ Blurry at Distance	_____ Flashes of Light	_____ Sudden Loss of Vision	_____ Print Appears Unstable
_____ Blurry at Near	_____ Spots or Floaters	_____ Carsickness	_____ Night Driving Difficulty

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=Grandmother 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_____
☐	☐	Strabismus (Eye Turn)_____	☐	☐	Other General Health Problems_____

To better assist your visual needs, please list any sports, activities or interests that are important to you (reading, card playing, musical instruments, sewing, television, reading in bed, workshop, crafts of any kind, golf, fishing, outdoor activities, etc.)

_____

_____

_____

_____

Tech Signature:_____ Initial Review Date _____

Doctor Signature:_____ Initial Review Date _____

Date Reviewed &Updated_____ Tech /Doctor Signature_____

Date Reviewed &Updated_____ Tech /Doctor Signature_____

Date Reviewed &Updated_____ Tech /Doctor Signature_____

Date Reviewed &Updated_____ Tech /Doctor Signature_____

Date Reviewed &Updated_____ Tech /Doctor Signature_____

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