HEALTH HISTORY

NAME: FIRST	MI	LAST	TITLE / NICKNAME	AGE	DATE

DATE OF BIRTH	BIRTH PLACE	WHO IS YOUR MEDICAL DOCTOR?

PRESENT OCCUPATION	LIVING INDEPENDENTLY?	OCCUPATIONAL DUTIES

HOBBIES AND INTERESTS

ALLERGIES	CAFFEINE: HOW OFTEN / HOW MUCH?

TOBACCO PRODUCTS:	ALCOHOL: HOW OFTEN / HOW MUCH?
☐ Yes ☐ NO	

CURRENT MEDICATIONS

Name/Dosage	How often?

SURGERY HISTORY

Eye Surgeries	Approx. Date
Other Surgeries	Approx. Date

YOUR OCULAR HISTORY

CHECK AND NOTE THE YEAR OF ANY OF THE FOLLOWING YOU HAVE HAD OR ARE CURRENTLY EXPERIENCING.

	YEAR		YEAR
Serious Eye Injury		Eye Pain	
Iritis or Eye Inflammation		Eye Redness	
Glaucoma or High Eye Pressure		Excessive Tearing	
Cataracts		Eye Discharge	
Lazy Eye		Double Vision	
Wandering Eye		Sensitivity to Light	
Diabetic Eye Problem		Blurred Vision	
Herpes Disease of the Eye		Spots, Floaters, or Shadows	
Eye Tumor		Halos in Vision	
Retinal Tear		Flashes of Light	
Bleeding in the Eye		Itching in Eyes	
Paralysis of Eye Muscles		Other:	
Other Eye Disease:			

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FAMILY HISTORY

INDICATE ANY BLOOD RELATIVE(S) WHO HAVE HAD THE FOLLOWING:

CONDITION	WHO?	CONDITION	WHO?
Glaucoma		Diabetes	
Retinal Disease		Cancer	
Blindness		Heart Disease	
Eye Tumor		High Blood Pressure	
Cross-Eyed		Stroke	
Corneal Disease		Cataracts	

YOUR GENERAL MEDICAL HISTORY

PLEASE CHECK AND NOTE THE YEAR OF ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD.

CONDITION	✓	YEAR	CONDITION	✓	YEAR
Diabetes			Rheumatic Fever		
Measles			Systemic Lupus		
Chicken Pox			Migraine Headaches		
Shingles/Herpes Zoster			Multiple Sclerosis		
AIDS or HIV Positive			Head Injury/Concussion		
Gonorrhea/Syphilis/PID			Chemical/Drug Poisoning		
Tuberculosis			Anemia		
Heart Attack			Hepatitis		
Heart Murmur			Neuritis		
Arthritis			Epilepsy		
Stroke			Polio or Meningitis		
Cancer (Note type below)			Amputation		
Colitis/Bowel Disease					

COMMENTS: _____

Patient Signature _____ **Date** _____