



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 Circle: YES NO				ALCOHOL: HOW OFTEN / HOW MUCH?		

CURRENT MEDICATIONS

SURGERY HISTORY

Name/Dosage	How often?	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.

CONDITION	✓	YEAR	CONDITION	✓	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:					

- TURN FORM OVER -

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** _____