HEALTH HISTORY FORM

Chart # _____

Name _____ Date _____

Describe in your own words why you are seeing us. 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, or fainting _____
☐	☐	Heart disease _____	☐	☐	Stroke _____
☐	☐	High blood pressure _____	☐	☐	(Women) Are you pregnant? _____
☐	☐	HIV _____	☐	☐	Other _____

OTHER SURGICAL HISTORY - Continue on back if more room needed. (Please include date and type.)

_____

_____

MEDICATIONS - List all medications (including eye drops) you are currently using (include 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?)
(Note: Relation to patient: F-Father M-Mother S-Sister B-Brother G-Grandparent U-Uncle A-Aunt)

Yes	No		Yes	No	
☐	☐	Cataracts _____	☐	☐	Retinal detachment _____
☐	☐	Corneal disease _____	☐	☐	Other eye problems _____
☐	☐	Crossed eyes / lazy eye _____	☐	☐	Diabetes _____
☐	☐	Diabetic retinopathy _____	☐	☐	Heart _____
☐	☐	Glaucoma _____	☐	☐	Stroke _____
☐	☐	Macular degeneration _____	☐	☐	Other _____

Physician's Signature _____