HEALTH HISTORY

PATIENT_____
DATE_____

Please list any **eye drops** or medications related to your eyes you are currently using. Please indicate how often you use the medication and which eye. Write "NONE" if you don't use any medication.

_____
_____
_____
_____

Please list all **medications** you are currently taking and the condition for which you are taking the medication. Write "NONE" if you don't take medication.

_____For:_____
_____For:_____
_____For:_____
_____For:_____
_____For:_____
_____For:_____
_____For:_____
_____For:_____
_____For:_____
_____For:_____
_____For:_____
_____For:_____

Please list medications for which you are **allergic**. Write "NONE" if you have no allergies to medications.

_____
_____
_____
_____

Please list any **SURGERY** you had to <u>your eyes</u> or <u>other</u> parts of your body. (Give Date and Type)

_____
_____
_____
_____

Please list your **Primary Care Physician**: (Full name, Address, and Phone number)

_____
_____
_____

<u>Please check all conditions that apply to YOU</u>

_ Recent Cold/Flu
_ Asthma
_ Chronic Lung Disease
_ High Blood Pressure: How long _____
_ High Cholesterol: How long_____
_ Palpitations or Irregular Heartbeat
_ Heart Murmur
_ Heart Attack or Chest Pain: When_____
_ Peripheral Vascular Disease
_ Diabetes: How long_____
_ Thyroid Disease
_ Reflux or Hiatal Hernia
_ Ulcers or Gastritis
_ Liver Disease
_ Anemia
_ Bruising/Bleeding Tendencies
_ Kidney Disease
_ Back Pain/Herniated Disc
_ Arthritis
_ TMJ Syndrome/ Jaw Clicking
_ Sleep Apnea
_ Epilepsy or Seizures: Last seizure_____
_ Stroke or Paralysis: When_____
_ Dizziness/Vertigo
_ Parkinson's Disease
_ Emotional Disorder
_ Alcohol or Drug Abuse
_ Smoking: How much_____How long_____
_ Do you drink alcohol? If so, how much_____
_ Do you live alone? YES NO
_ Other: Please specify: _____

Please check all that apply to your **<u>FAMILY:</u>**

_ Cataracts Who_____
_ Glaucoma Who_____
_ Blindness Who_____
_ Macular Degeneration Who_____
_ Diabetic Retinopathy Who_____
_ Other Eye Diseases: (Please specify) _____
_ High Blood Pressure Who_____
_ Heart Problems Who_____
_ Diabetes Who_____
_ Other Medical Problems (Please specify)___
_____

Reviewed & Updated:___/____/___Tech_____
Reviewed & Updated:___/____/___Tech_____
Reviewed & Updated:___/____/___Tech_____
Reviewed & Updated:___/____/___Tech_____