HEALTH HISTORY

PATIENT___________________________________
DATE______________________________________

Please list all **Eye drops/medications & dosages** you are currently taking.

☐____
☐____
☐____
☐____

Please list all **Medications & dosages** you are currently taking & the condition they are for.

☐_________________Dose:_________For:___________
_________________Dose:_________For:___________
☐_________________Dose:_________For:___________
☐_________________Dose:_________For:___________
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☐_________________Dose:_________For:___________
☐_________________Dose:_________For:___________
☐_________________Dose:_________For:___________
☐_________________Dose:_________For:___________

Please list all **Allergies** & reactions.

☐____
☐____
☐____
☐____

Please list any **SURGERY** you have had.
(Give Date and Type)

☐____
☐____
☐____
☐____

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

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Please check all conditions that apply to YOU

- ☐☐ 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______
- ☐☐ Other: Please specify: ________________

Please check all that apply to your **FAMILY:**
(Blood related, do not include spouses.)

- ☐☐ 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)___

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