Health History

Yes No

- □ □ Asthma _____
- □ □ COPD _____
- □ □ Tuberculosis _____
- □ □ Diabetes: Type I _____ / Type II _____# of yrs____
- □ □ Insulin Dependent _____
- □ □ Kidney Disease _____
- □ □ Psychiatric Disorder _____
- □ □ Any nervous disorder _____
- □ □ Alzheimer's _____
- □ □ Dementia _____
- □ □ Heart Disease _____
- □ □ High Blood Pressure _____
- □ □ Carotid Artery Disease _____ # of yrs _____
- □ □ Stroke _____
- □ □ High Cholesterol _____

Yes No

- □ □ Migraines _____
- □ □ Head or Spinal Injuries _____
- □ □ Seizures, Convulsions, or Fainting _____
- □ □ Diagnosed with Cancer _____
- □ □ Allergy to Iodine _____
- □ □ Allergy to Latex _____
- □ □ HIV/AIDS _____
- □ □ Hepatitis _____
- □ □ Dental Cavities?_____
- □ □ Suffering from any other disease _____
- □ □ Are your immunizations current? _____
- □ □ Do you consume alcoholic beverages? _____
- □ □ Current smoker? / Former smoker? ____# of yrs quit
- □ □ Within the last twelve (12) months have you taken any illegal substances? _____

Please list ALL medications AND dosages you are currently taking. (Include vitamins, eye drops, and over the counter medications)

Name of medication	*Dosage*	*Name of medication*	*Dosage*

Please list ANY allergies to medications AND reactions:

Name of medication	*Reaction*

Have you ever been diagnosed with the following in the past?

Yes No

- □ □ Cornea Disease
- □ □ Glaucoma
- □ □ Macular Degeneration
- □ □ Iritis

Yes No

- □ □ Diabetic Retinopathy
- □ □ Cataracts
- □ □ Amblyopia (Lazy Eye)
- □ □ Retina Disease

Surgical Ocular History

	Right eye	*Left eye*
Cataract Surgery: Date:		
Retina Surgery: Date:		
Lasik Surgery: Date:		
Cornea Surgery: Date:		

Eye Injuries (Please include Date and type of injury)

_____

_____

_____

YOUR SURGERY HISTORY *(Please include Date & Type)*

_____

_____

_____

FAMILY HISTORY (Has anyone in your family (blood relative) had any of the following?)

(PLEASE NOTE RELATION TO PATIENT) **M –Mother F- Father S-Sister B-Brother GF-Grandfather GM-Grandmother U-Uncle A-Aunt**

Yes No

- □ □ _____Diabetes
- □ □ _____Diabetic retinopathy
- □ □ _____Cataracts
- □ □ _____Retinitis Pigmentosa
- □ □ _____Macular Degeneration
- □ □ _____Heart Disease

Yes No

- □ □ _____Glaucoma
- □ □ _____Cornea Disease
- □ □ _____Retinal Detachment
- □ □ _____Stroke
- □ □ _____Other Eye Problems
- □ □ _____Other General Health Problems

Social History *(circle one)*

Are you currently: *Married / Widowed / Single / Divorced*

Living Conditions: *Lives alone / Lives in Nursing Home / Lives with caregiver, family, or spouse*

Driving*: Yes No*

Occupation: _____

Patient Signature:_____ ***Date:*** _____