Health History

Name: ___________________________ **Date Of Birth:**__________________________

Personal Eye History

Yes No
___ ___ Glaucoma
___ ___ Macular Degeneration
___ ___ Cataract Surgery
___right ___left
___ ___ Retina Surgery ______________
____
___ ___ Other_________________________

Personal Medical History

Yes No
___ ___ Arthritis
___ ___ Cancer (type)__________________
___ ___ Rashes or itching
___ ___ Diabetes ___Type 1 ___Type 2
Insulin: ___Yes ___No
For how long (on insulin)?_____
___ ___ Bowel problems
___ ___ Frequent Headaches
___ ___ Confusion/Memory loss
___ ___ Hearing loss or ringing
___ ___ Heart ________________________
___ ___ HIV/AIDS
___ ___ High Blood Pressure
___ ___ High Cholesterol
___ ___ Kidney Problems ______________
___ ___ Lung/Breathing Problems________
___ ___ MRSA (Methicillin-resistant Staphylococcus Aureus)
___ ___ Recent weight changes
___ ___ Stroke
___ ___ Thyroid Disease
___ ___ Allergic reaction to Latex
___ ___ Allergic reaction to Medication
____
____
____
____

Height ___________ Weight ________
Other ________________________________
____
____

Surgeries in lifetime, other than eyes

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____

Any implanted electronic devices (pacemaker, defibrillator, etc.)? ___Yes ___No

Social History

Tobacco/Nicotine use ___Yes ___No
Currently: How much daily? ______________
Formerly: Quit when?____________________
Alcohol use ___Yes ___No
Currently: How much daily?____________
Formerly: Quit when? __________________

Family History

Yes No
___ ___ Retina Problems _____________
___ ___ Diabetes
___ ___ Cancer _____________________
___ ___ Heart Disease
___ ___ High Blood Pressure
___ ___ Glaucoma
___ ___ Other

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For Office Use Only
______________**Reviewed**______________
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