HEALTH HISTORY

PATIENT NAME _____

LAST FIRST MI

DO YOU WEAR: Glasses ☐ YES ☐ NO Contacts ☐ YES ☐ NO Are you interested in new contacts? ☐ YES ☐ NO

SOCIAL HISTORY

(THIS HELPS US EVALUATE YOUR VISION COMPLAINTS)

HAVE YOU RECENTLY TRAVELED OUTSIDE THE U.S.? ☐ YES ☐ NO IF SO, WHERE?_____

DO YOU SMOKE? ☐YES ☐ NO HOW MANY PACKS PER DAY? _____ HOW MANY YEARS? _____

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO HOW MANY PER DAY? _____ PER WEEK?_____ ☐ SELDOM

PERSONAL MEDICAL HISTORY

	NO	YES	If yes, please describe:
HEADACHES			
STROKE			
HAY FEVER/ENT			
THYROID			
HIGH BLOOD PRESSURE			
CANCER			
DIABETES			
RESPIRATORY			
HEART DISEASE			
LIVER DISEASE			
SKIN DISEASE			
SEIZURES			
KIDNEYS			
MUSCLES			
DEPRESSION			
ARTHRITIS			
OTHER			

PERSONAL EYE MEDICAL HISTORY

	NO	YES	If yes, please describe:
MACULAR DEGENER.			
LAZY EYE			
CATARACTS			
GLAUCOMA			
OTHER			

FAMILY HISTORY

	NO	YES	If yes, please indicate family member:
HEADACHES			
ARTHRITIS			
HEART DISEASE			
RESPIRATORY			
THYROID			
HIGH BLOOD PRESSURE			
CANCER			
DIABETES			
OTHER			

FAMILY EYE MEDICAL HISTORY

	NO	YES	If yes, please indicate family member:
LAZY EYE			
CROSSED EYES			
CATARACTS			
GLAUCOMA			
MACULAR DEGENER.			
OTHER			

ANY KNOWN ALLERGIES TO MEDICATIONS
CURRENT MEDICATIONS
CURRENT EYE MEDICATIONS
PLEASE LIST PAST EYE SURGERIES
PLEASE LIST ANY SURGERIES

Signature: _____

Date: _____

Updated/Reviewed:

Initial	Date