HEALTH HISTORY

NAME: ____________________ DATE: ____________________

YES	NO		YES	NO	
☐	☐	Asthma ____________	☐	☐	Head or Spinal Injuries____________
☐	☐	Kidney Disease____________	☐	☐	Seizures, Convulsions, or Fainting____________
☐	☐	Tuberculosis ____________	☐	☐	Extensive Confinement by Illness or Injury_____
☐	☐	Diabetes IDDM/Type II - # of yrs. ____	☐	☐	Temporal Arteritis____________
☐	☐	Insulin ____________	☐	☐	Suffering from any other disease____________
☐	☐	Migraines ____________	☐	☐	Carotid Artery Disease____________
☐	☐	Psychiatric disorder ____________	☐	☐	Permanent defect from Illness, Disease or Injury
☐	☐	Any nervous disorder ____________	☐	☐	(Women) Are you pregnant?____________
☐	☐	Heart Disease____________	☐	☐	High Blood Pressure____________
☐	☐	Ulcer ____________	☐	☐	Stroke____________
☐	☐	Hypertension ____________	☐	☐	HIV____________
☐	☐	Sickle Cell Anemia____________	☐	☐	Other Diagnosed Health Problems____________

Please List **All** Medication / Vitamins You Are Taking:	Please List All Allergies
____________________	____________________
____________________	____________________
____________________	____________________

YOUR OCULAR HISTORY *(Have you been diagnosed with any of the following in the past?)*

YES	NO		YES	NO	
☐	☐	Cataracts____________	☐	☐	Cornea Disease____________
☐	☐	Retina Disease____________	☐	☐	Glaucoma____________
☐	☐	Crossed Eyes____________	☐	☐	Injury____________
☐	☐	Iritis____________	☐	☐	Other Eye Disorders:____________

Cataract Surgery (Date of Surgery)	Right	Left	Do you have a lens implant?	☐ Yes	☐ No
Retina Surgery (Date of Surgery)	Right	Left			
Explanation of Eye Injury:					

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

(NOTE RELATION TO PATIENT) F - Father M - Mother PA - Paternal MA - Maternal S - Sister
B - Brother GF - Grandfather GM - Grandmother U - Uncle A - Aunt

YES	NO		YES	NO	
☐	☐	Glaucoma____________	☐	☐	Diabetes IDDM/Type II____________
☐	☐	Cataracts____________	☐	☐	Heart____________
☐	☐	Cornea Disease____________	☐	☐	Diabetic Retinopathy____________
☐	☐	Macular Degeneration____________	☐	☐	Retinal Detachment____________
☐	☐	Retinitis Pigmentosa____________	☐	☐	Stroke____________
☐	☐	Other Eye Problems____________	☐	☐	Other General Health Problems____________

SURGICAL HISTORY *(Please Include Date and Type)*

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Tech Signature ____________________