

HEALTH HISTORY

Name _____ Date _____

YES

NO

- Asthma
 Kidney Disease
 Tuberculosis
 Diabetes Type I _____ years
 Diabetes Type II _____ years
 Migraines
 Psychiatric Disorder
 Any nervous disorder
 Heart Disease
 Ulcer
 HIV

YES

NO

- Head or Spinal Injuries
 Seizures, Convulsions, or Fainting
 Extensive Confinement by Illness or Injury
 Temporal Arteritis
 Sickle Cell Anemia
 Carotid Artery-Disease
 Permanent defect from Illness or Injury
 Are you pregnant?
 High Blood Pressure
 Stroke
 Suffering from any other disease

**PLEASE LISE ALL MEDICATIONS YOU
ARE CURRENTLY TAKING:**

ALLERGIES: _____

SOCIAL HISTORY

Marital Status: S M D W

Tobacco Use? Y N Pack/Years _____

Alcohol Use? Y N Drinks/Week _____

Occupation? _____

OCCULAR HISTORY (HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?)

YES

NO

- Cataracts _____
 Retina Disease _____
 Crossed Eyes _____
 Iritis _____

YES

NO

- Cornea Disease _____
 Glaucoma _____
 Injury _____
 Other Eye Disorders _____

Date of Cataract Surgery: Right _____ Left _____

Do you have a lens implant? () YES () NO

Date of Retina Surgery: Right _____ Left _____

Date of Any Other Eye Surgery _____

Explanation: _____

FAMILY HISTORY (HAS ANYONE IN YOUR FAMILY (BLOOD RELATIVE) HAD THE FOLLOWING?)

YES

NO

- Glaucoma _____
 Cataracts _____
 Heart Disease _____
 Macular Degeneration _____
 Retinitis Pigmentosa _____
 Other Eye Problems _____

YES

NO

- Cornea Disease _____
 Diabetes Type I or II _____
 Diabetic Retinopathy _____
 Retinal Detachment _____
 Stroke _____
 Other Health Problems _____

Doctors Initials _____