HEALTH HISTORY

Patient Name: ____ Date: __________________________

♦ Please check any condition that applies to **yourself or any member of your family** (parents, grandparents, siblings, children; living or deceased):

	Self	Family
Cancer	___	___
Diabetes	___	___
Heart Disease	___	___
High Blood Pressure	___	___
Other general health problems	___	___
Blindness	___	___
Cataracts	___	___
Glaucoma	___	___
Lazy eye	___	___
Macular Degeneration	___	___
Retinal Detachment	___	___
Retinitis Pigmentosa	___	___
Other eye condition	___	___

♦ Have **you** experienced or have you been diagnosed with any of the following?

Yes	No	
□	□	Fever, weight loss/gain
□	□	Headaches
□	□	Migraines
□	□	Seizures
□	□	Thyroid condition
□	□	Asthma
□	□	Emphysema
□	□	Kidney/Bladder disorder
□	□	Arthritis
□	□	Anemia
□	□	HIV/AIDS
□	□	Anxiety
□	□	Depression
□	□	Other medical conditions: _______________

♦ Do you smoke or use tobacco? □ Yes □ No
♦ Do you drink alcohol? □ Yes □ No
♦ (Females only) Are you: Pregnant? □ Yes □ No Nursing? □ Yes □ No
♦ List type and date of prior surgeries (including eye surgeries): ______________________________
____

♦ Do you have any environmental/seasonal allergies? □ Yes □ No If yes, please check the following eye-related allergy symptoms you experience: __ itching __ burning __ redness __ watering

♦ Please list all **medications** you are currently taking:

____
____
____
____

♦ Please list all medications you are **allergic** to:

____
____
____
____

♦ **Ocular History** -Please check all of the symptoms that apply to **you**:

Yes	No	
□	□	Blurred vision - distance
□	□	Blurred vision - near
□	□	Double vision
□	□	Dry eyes
□	□	Eye infection
□	□	Eye injury
□	□	Eyestrain
□	□	Floaters (spots)
□	□	Flashes of lights
□	□	Light sensitive
□	□	Burning eyes
□	□	Watery eyes

Are you interested in laser eye surgery? □ Yes □ No
Do you wear contact lenses now? □ Yes □ No
Are you interested in wearing contacts? □ Yes □ No
If yes, are you interested in:
colored contacts □ Yes □ No
sleeping in your contacts □ Yes □ No

Do you wear glasses? □ Yes □ No
Do you work on a computer? □ Yes □ No
Do you have trouble with glare? □ Yes □ No
Please list hobbies/sports you participate in:
____
____