

HEALTH HISTORY

SOCIAL HISTORY: HEIGHT: _____ WEIGHT: _____

DO YOU USE TOBACCO PRODUCTS? YES NO IF YES, AMOUNT/HOW LONG? _____

DO YOU USE DRINK ALCOHOL? YES NO IF YES, AMOUNT/HOW LONG? _____

YES NO

- Asthma _____
- Kidney Disease _____
- Tuberculosis _____
- DIABETES IDDM/Type II - # of years _____
- Insulin _____
- Migraines _____
- Psychiatric Disorder _____
- Any Nervous Disorder _____
- Heart Disease _____
- Ulcer _____
- Hypertension _____
- Sickle Cell Anemia _____

YES NO

- Head or Spinal Injuries _____
- Seizures, Convulsions, or Fainting _____
- Extensive Confinement by Illness or Injury _____
- Temporal Arteritis _____
- Suffering from any other disease _____
- Carotid Artery Disease _____
- Permanent defect from illness, disease or injury _____
- Women (Are you pregnant?) _____
- Stroke _____
- HIV _____
- 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 the past?)*

YES NO

- Cataracts _____
- Retina Disease _____
- Crossed Eyes _____
- Iritis _____

YES NO

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

Cataract Surgery (Date of Surgery)	Right	Left	Do you have a lens implant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Retina Surgery (Date of Surgery)	Right	Left	Lasik/Refractive Surgery (Date of Surgery)
Explanation of Eye Injury:			

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

(NOTE RELATION TO PATIENT)

YES NO

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

YES NO

- Diabetes IDDM/Type II _____
- Heart _____
- Diabetic Retinopathy _____
- Retinal Detachment _____
- Stroke _____
- Other General Health Problems _____