HEALTH HISTORY

PATIENT NAME: _____**DATE:**_____

Your Medical Doctor_____ **Allergies:**_____

Have you ever been treated for any of the following medical conditions?

Yes	No		Yes	No	
☐	☐	Diabetes: # of years_____Taking Insulin?_____	☐	☐	Carotid Artery Disease_____
☐	☐	Arthritis: Osteo___ Rheumatoid___Other_____	☐	☐	Temporal Arteritis__-_____
☐	☐	Lung disease: Asthma__TB__Other_____	☐	☐	Head or Spinal Injury_____
☐	☐	Kidney Disease: Stones___Other_____	☐	☐	Seizures, Convulsions, Tremors, or Fainting____
☐	☐	Thyroid Disease:Type_____	☐	☐	Hormone Replacement_____
☐	☐	Neurological Disease_____	☐	☐	(Women) Are you pregnant or nursing?_____
☐	☐	Headaches or Migraines_____	☐	☐	Immune Disease:Leukemia__Lupus_HIV/AIDS_ Lymph Node Swelling__Other_____
☐	☐	Cancer -Type:_____			
☐	☐	Neurologic Disease_____	☐	☐	Stroke_____
☐	☐	Heart Disease:Heart Attack__Angina__ Bypass_____ Heart Failure____Other_____	☐	☐	High Blood Pressure: # of years_____
			☐	☐	Blood Disorder:Anemia__Other_____
☐	☐	GI Disorder: Ulcer__Hepatitis__Other_____	☐	☐	Serious Trauma_____
☐	☐	Any other Disease/Disorder Not Listed:_____			

Your Eye History: Have you ever had any eye disease? Yes ☐ No ☐ If YES, please check all that apply.

___Glaucoma ___Cataracts ___Crossed eyes/strabismus ___Macular degeneration
___Iritis ___Eye Injury:_____ ___Dry eyes ___Lazy eye/amblyopia
___Blepharitis ___Other retinal disease:_____ ___Corneal Disease:_____

Have you ever had eye surgery? Yes ☐ No ☐ If YES, list:

Surgery	Eye	Date	Surgery	Eye	Date	Surgery	Eye	Date

Have you ever had other surgery? Yes ☐ No ☐ If YES, list:?

Surgery	Date	Surgery	Date	Surgery	Date

Do you take any medications (including eye medications)? Yes ☐ No ☐ If YES, please list:_____
_____
_____
_____

Social History

Are you or have you ever been regularly employed? Yes ☐ No ☐ If YES, what kind of work do/did you do?_____
How much alcohol do you drink? (type,# per day or week)_____
Do you live alone? Yes ☐ No ☐
Have you ever smoked regularly? Yes ☐ No ☐ Do you smoke now ? Yes ☐ No ☐ If no, when did you stop?_____
How much do/did you smoke?_____For how many years?_____

PREFERRED LANGUAGE_____**RACE**_____

PREFERRED CONTACT METHOD PLEASE CIRCLE ONE: HOME CELL WORK OR E-MAIL_____