Health History

Patient Name:_____ Date of Birth:_____

Please answer each question. Check yes or no.

**** PLEASE PRINT ****

1. Do you have or have you ever had any of the following?

	YES	NO		YES	NO
Cataracts ……..	___	___	Arthritis……..	___	___
Glaucoma……	___	___	Thyroid disease……..	___	___
Macular degeneration……..	___	___	Stroke……	___	___
Corneal disease……..	___	___	Cancer……	___	___
"Lazy Eye"……..	___	___	Migraine headaches……..	___	___
Retinal problems……..	___	___	Seasonal allergies……..	___	___
Diabetes……..	___	___	Wear contact lenses……..	___	___
Do you take Insulin? ……..	___	___	Family history of diabetes……..	___	___
High blood pressure……..	___	___	Family history of glaucoma……	___	___
Heart disease……..	___	___	Family history of heart disease….	___	___
Asthma……	___	___	Family history of cancer……..	___	___

2. Have you ever had an injury to your eye(s) ___ ___
   If yes, please explain_____
   _____

3. Have you ever had any surgery on your eye(s) ___ ___
   If yes, please indicate type of surgery, to which eye and date of surgery_____
   _____
   _____

4. Please list any prescription and non-prescription eye drops you are using….
   _____
   _____

*******PLEASE TURN OVER PAGE AND COMPLETE OTHER SIDE**************

For Doctor's Use Only

Notes:_____
_____
_____
_____
_____

Date Reviewed and Updated

___/___/_____ ____	___/___/_____ ____	___/___/_____ ____	___/___/_____ ____
___/___/_____ ____	___/___/_____ ____	___/___/_____ ____	___/___/_____ ____
___/___/_____ ____	___/___/_____ ____	___/___/_____ ____	___/___/_____ ____

	YES	NO
7. Are you in good health now?.....	___	___
8. Are you now under the care of a physician?.....	___	___
If yes, what is the condition being treated?_____		
9. Have you ever been hospitalized or had a serious illness?.....	___	___
If yes, please explain_____		
10. (Women) Are you pregnant? If so, please provide due date_____	___	___
11. **Do you use tobacco in any form? If yes, how much**_____	___	___
12. Do you use alcoholic beverages (more than 2 drinks per day)?_____	___	___
13. Do you drive.....	___	___

14. Do you have or have you ever had any of the following?

GENERAL	**YES**	**NO**
Tire easily, weakness.....	___	___
Marked weight change.....	___	___
Night sweats.....	___	___
Persistent fever.....	___	___
SKIN		
Eruptions (rash) hives.....	___	___
Change in skin color.....	___	___
EARS		
Loss of hearing.....	___	___
Ringing in ears.....	___	___
NOSE		
Frequent nosebleeds.....	___	___
Sinus problems.....	___	___
THROAT		
Soreness/horseness.....	___	___
NERVOUS SYSTEM		
Stroke.....	___	___
Headaches.....	___	___
Convulsions/epilepsy.....	___	___
Numbness/tingling.....	___	___
Dizziness/fainting.....	___	___
Psychiatric treatment.....	___	___
RESPIRATORY		
Tuberculosis.....	___	___
Emphysema.....	___	___
Hay fever.....	___	___
Persistent cough.....	___	___
Sputum production (phlegm).....	___	___
Cough up bloody sputum.....	___	___
Difficulty breathing while lying down	___	___
Asthma	___	___
BARRIERS TO TREATMENT		
Visual Impairment	___	___
Difficulty Hearing	___	___
Any language barrier	___	___
Any cultural barriers to receiving treatment	___	___
Any religious barriers to receiving treatment	___	___

HEART/BLOOD VESSELS	**YES**	**NO**
Rheumatic fever.....	___	___
Heart mumur.....	___	___
Chest pain/discomfort.....	___	___
Heart attack.....	___	___
Shortness of breath.....	___	___
Swelling of ankles.....	___	___
Heart Surgery.....	___	___
BONE/MUSCLES		
Rheumatism.....	___	___
Artificial joints/limbs.....	___	___
DIGESTIVE SYSTEM		
Hepatitis.....	___	___
Jaundice.....	___	___
Ulcers.....	___	___
Change in appetite.....	___	___
Black, bloody or pale stools..	___	___
URINARY		
Kidney disease.....	___	___
Increase in frequency of urination (night).....	___	___
Burning on urination.....	___	___
Urethral discharge.....	___	___
Bloody urine.....	___	___
BLOOD		
Bruise easily.....	___	___
Anemia.....	___	___
Blood transfusion.....	___	___
OTHER		
Radiation therapy.....	___	___
Chemotherapy.....	___	___
Tumors of growths.....	___	___
HIV+.....	___	___
AIDS.....	___	___
Do you have an Advance Directive or Living Will?	___	___