PATIENT HEALTH HISTORY

Name: _____Date: _____Date of last exam: _____

Occupation: _____Hobbies/Activities: _____

What is your main reason for coming here today? _____

Do you or your immediate family (parents/siblings/children) have any of the following conditions?
(Checked box indicates **YES**, blank boxes indicate **NO**)

Allergies	❒ Self		Amblyopia	❒ Self	❒ Family
Respiratory (lung) disease	❒ Self		Turned eye	❒ Self	❒ Family
Cancer	❒ Self	❒ Family	Color "blind"	❒ Self	❒ Family
Diabetes	❒ Self	❒ Family	Light sensitive	❒ Self	
Elevated cholesterol	❒ Self		Dry eyes	❒ Self	
Heart problems	❒ Self	❒ Family	Floaters / spots	❒ Self	
High blood pressure	❒ Self	❒ Family	Flashing lights	❒ Self	
Thyroid	❒ Self		Retinal detachment	❒ Self	❒ Family
Migraine headaches	❒ Self		Glaucoma	❒ Self	❒ Family
Head trauma	❒ Self		Cataracts	❒ Self	❒ Family
Liver Disease	❒ Self		Macular degeneration	❒ Self	❒ Family
Renal (kidney) Disease	❒ Self		Blindness	❒ Self	❒ Family

Have you ever had eye surgery or injury ❒ No ❒ Yes If yes, please explain_____
_____

Are you currently under a physician's care for a medical condition? ❒ No ❒ Yes
If yes, please note doctor's name and condition_____

Are you taking any medications? ❒ No ❒ Yes If yes, please list_____
_____

Any allergies to medications? ❒No ❒ Yes If yes, please list_____

Do you experience any of the following (with your correction if you wear glasses or contacts)?

❒ Distance vision isn't clear
❒ Near vision isn't clear
❒ Double vision
❒ Night vision difficulties
❒ Problems with glare
❒ Eye pain

Social History
Are you pregnant or nursing? ❒ Yes ❒ No

Do you drive? ❒ Yes ❒ No Describe any difficulties_____

Do you use tobacco? ❒ Yes ❒ No Type_____Amount_____

Do you drink alcohol? ❒ Yes ❒ No

Have you been exposed to any communicable diseases? ❒ Yes ❒ No

Doctor's signature_____ Date_____ Reviewed_____ Date_____
Reviewed_____ Date_____