HEALTH HISTORY

Welcome to our Practice. Please fill out the information found below to the best of your ability.

Today's Date _____

Patient Name _____ Birth Date _____

Eye Health History

Have you ever had the following eye conditions? (Check "No" or "Yes", leave blank if uncertain.)

Glaucoma	☐ No	☐ Yes
Cataracts	☐ No	☐ Yes
Loss of Vision	☐ No	☐ Yes
Macular Degeneration	☐ No	☐ Yes
Eye Surgery or Injury	☐ No	☐ Yes
Retinal Detachment	☐ No	☐ Yes
Loss of Side Vision	☐ No	☐ Yes
Double Vision	☐ No	☐ Yes
Dry Eyes	☐ No	☐ Yes
Red Eyes	☐ No	☐ Yes
Lazy Eye/Crossed Eye	☐ No	☐ Yes
Itchy Eyes	☐ No	☐ Yes
Sandy or Gritty Eyes	☐ No	☐ Yes
Burning	☐ No	☐ Yes
Excess Tearing	☐ No	☐ Yes
Glare/Light Sensitivity	☐ No	☐ Yes
Floaters or Spots	☐ No	☐ Yes
Eye Infection	☐ No	☐ Yes
Drooping Eyelid	☐ No	☐ Yes

Explanation: _____

General Health History

Primary Care Physician _____

Previous Hospitalizations/Surgeries/Serious Illnesses _____

Medications (Include Prescriptions and Non-Prescriptions) _____

Allergies to Medications _____

Patient Social History (Check Appropriate Answer)

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Previously, but not in the past ____ year(s) ☐ Current packs/day:

Do you currently wear: ☐ Contact Lenses ☐ Glasses ☐ Neither

Family Medical History

Is there a family history of the following conditions? (Check Appropriate Answer)

Glaucoma	☐	_____
Cataracts	☐	_____
Retinal Detachment	☐	_____
Diabetes	☐	_____
Heart Disease	☐	_____
Cancer	☐	_____