

HEALTH HISTORY FORM

Name: _____

Today's Date: _____

Family Physician: _____

Birth Date: _____

How were you referred? _____

MEDICATIONS

Eye Medications/Drops:	All other medications and pills: (including over the counter)
Allergies: (Drug/Environmental)	

(When appropriate, list dates and eye involved)

Circle/List all eye problems/previous injuries: <table style="width: 100%;"> <tr> <td style="width: 50%;">Retinal detachment</td> <td style="width: 50%;">Glaucoma</td> </tr> <tr> <td>Macular degeneration</td> <td>Cataract</td> </tr> <tr> <td>Corneal transplant</td> <td>Iritis/Uveitis</td> </tr> <tr> <td>Injury(s):</td> <td>Other:</td> </tr> </table>	Retinal detachment	Glaucoma	Macular degeneration	Cataract	Corneal transplant	Iritis/Uveitis	Injury(s):	Other:	Circle/List all eye surgeries: <table style="width: 100%;"> <tr> <td style="width: 60%;">Cataract</td> <td style="width: 15%;">R / L</td> <td style="width: 25%;">date: _____</td> </tr> <tr> <td>Glaucoma</td> <td>R / L</td> <td>date: _____</td> </tr> <tr> <td>Refractive</td> <td>R / L</td> <td>date: _____</td> </tr> <tr> <td colspan="3">Other surgeries:</td> </tr> </table>	Cataract	R / L	date: _____	Glaucoma	R / L	date: _____	Refractive	R / L	date: _____	Other surgeries:		
Retinal detachment	Glaucoma																				
Macular degeneration	Cataract																				
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Injury(s):	Other:																				
Cataract	R / L	date: _____																			
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Refractive	R / L	date: _____																			
Other surgeries:																					

PAST MEDICAL HISTORY

Do you have any of the following medical illnesses? (circle all that apply): <table style="width: 100%;"> <tr> <td style="width: 50%;">High blood pressure</td> <td style="width: 50%;">Heart Disease</td> </tr> <tr> <td>Diabetes</td> <td>Depression</td> </tr> <tr> <td>Stroke</td> <td>Clotting disorder</td> </tr> <tr> <td>AIDS</td> <td>Cancer</td> </tr> <tr> <td>Asthma</td> <td>Atrial Fibrillation</td> </tr> <tr> <td>MRSA</td> <td>Pacemaker</td> </tr> <tr> <td>TB</td> <td></td> </tr> </table>	High blood pressure	Heart Disease	Diabetes	Depression	Stroke	Clotting disorder	AIDS	Cancer	Asthma	Atrial Fibrillation	MRSA	Pacemaker	TB		List any other medical illnesses or major surgery:
High blood pressure	Heart Disease														
Diabetes	Depression														
Stroke	Clotting disorder														
AIDS	Cancer														
Asthma	Atrial Fibrillation														
MRSA	Pacemaker														
TB															

PERSONAL/SOCIAL/FAMILY HISTORY

Smoking history: Y / N # of packs/day? _____ # of years? _____ Quit? _____										
Alcohol Use: No Rare Weekly Daily Recreational Drugs: In past Currently No										
Social History: Marital status _____ Occupation: _____ Pregnant? Y / N										
Family History: (please circle all that have occurred to other members of your family)										
<table style="width: 100%;"> <tr> <td style="width: 50%;">Retinal detachment</td> <td style="width: 50%;">Loss of vision at a young age</td> </tr> <tr> <td>Macular degeneration</td> <td>Congenital defects</td> </tr> <tr> <td>Corneal transplant</td> <td>Blood clotting problems</td> </tr> <tr> <td>Glaucoma</td> <td>Heart disease</td> </tr> <tr> <td>Cataract</td> <td>Diabetes</td> </tr> </table>	Retinal detachment	Loss of vision at a young age	Macular degeneration	Congenital defects	Corneal transplant	Blood clotting problems	Glaucoma	Heart disease	Cataract	Diabetes
Retinal detachment	Loss of vision at a young age									
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Glaucoma	Heart disease									
Cataract	Diabetes									

Please complete other side

Physician signature/date

REVIEW OF SYSTEMS (please circle all that apply):

GENERAL: NONE / fever / weight loss / no appetite / fatigue / very thirsty

Other: _____

EYES: NONE / blurring / tearing / burning / itching / pain

Other: _____

EARS/ NOSE/THROAT: NONE / poor hearing / sinus problems

Other: _____

HEART: NONE / high/low blood pressure / slow beat / irregular beat / heart failure

Other: _____

LUNGS: NONE / asthma / emphysema / bronchitis

Other: _____

ABDOMINAL: NONE / diarrhea / constipation / ulcer / GI bleeding

Other: _____

GENITAL/URINARY: NONE / kidney stones / infection / impotence / frequent urination

Other: _____

SKIN/JOINTS: NONE / rashes / breast lumps / cold hands & feet / easy bruising / arthritis

Other: _____

NEUROLOGICAL: NONE / migraines / headaches / stroke / Alzheimer's

Other: _____

BLOOD: NONE / anemia / prior transfusion / HIV virus / easy bruising

Other: _____

Psychiatric: NONE / depression / bipolar / anxiety / poor memory

Other: _____

ENDOCRINE: NONE / low thyroid / high thyroid / insulin diabetes / non-insulin diabetes

Other: _____

Physician signature / Date