



# Health History

Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M F Age \_\_\_\_\_ Date \_\_\_\_\_

Do you wear glasses? NO YES If, YES (Please check all that apply)

All the time  Distance Only  Work/Safety  Reading  Computer  Other \_\_\_\_\_

Have you ever worn contact lenses? YES NO Are you interested in wearing contact lenses? YES NO

Are you interested in LASIK? YES NO Do you work at a computer/video display terminal? YES NO

What hobbies or sports do you participate in? \_\_\_\_\_

Have you been diagnosed with or treated for any of the following:

Y	N		Y	N	
		Lung Disease. Type:			Head or Spinal Injuries
		Kidney Disease			Seizures, Convulsions, Fainting
		Arthritis			Temporal Arteritis
		Diabetes. No. of years:			Carotid Artery Disease
		Neurological Disease			Pregnant or Nursing
		Migraines			Stroke
		Psychiatric Disorder			HIV/AIDS. No. of years:
		Nervous Disorder			Extensive Confinement From Illness or Injury
		Heart Disease			Suffering From Other Disease
		Gastrointestinal Disease. Type:			Do You Smoke? How much:
		High Blood Pressure. No. of years:			Do You Drink? How often:
		Scarring/Keloids			Allergic to Latex or Rubber
		Thyroid			

Who is your medical doctor? \_\_\_\_\_

Please list all medications you are taking \_\_\_\_\_

Please list all medication allergies \_\_\_\_\_

Have you been diagnosed with or treated for any of the following:

Y	N		Y	N	
		Cataracts			Corneal Disease
		Lazy Eye			Glaucoma
		Retinal Disease			Iritis
		Eye Injury			Other Eye Disorders:

Have you had Cataract Surgery?

**Right Eye:** NO YES: Surgery Date \_\_\_\_\_ Lens Implant: N Y **Left Eye:** NO YES: Surgery Date \_\_\_\_\_ Lens Implant: N Y

Other Eye Surgery?

**Right Eye:** NO YES: Surgery Date \_\_\_\_\_ **Left Eye:** NO YES: Surgery Date \_\_\_\_\_

Has any family member (Mother, Father, Sisters or Brothers) been treated for the following:

Y	N		Y	N	
		Glaucoma			Retinal Detachment
		Cataracts			Corneal Disease
		Macular Degeneration			Retinitis Pegmentose
		Diabetic Retinopathy			Heart Disease
		Diabetes			Stroke
		Other Eye Problems:			Other Health Conditions:

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_