Patient Health History

NAME:_____

1. Reason for your visit today:

_____

2. Do you wear:
☐ Glasses
☐ Contact lenses _____soft_____RGP
☐ Do you have prism in your glasses? ____Yes____No

3. Do you have problems with crossed eyes or eyes that turn out? ____Yes____No

4. Do you have lazy eye/amblyopia?____Yes____No

5. Have you ever had any injury to your eyes? ____Yes____No
Please explain_____

6. Have you ever been diagnosed with
☐ Glaucoma
☐ Cataract
☐ Macular degeneration

7. Do you have a family history of eye disease? ____Yes____No
If yes, please explain:

_____
_____
_____

8. Please check any medical conditions you or a family member has:

	SELF	RELATIVE/WHO
Autoimmune disease	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Cancer/tumor	☐	☐
Cholesterol	☐	☐
Stroke	☐	☐
Diabetes	☐	☐
Hypertension	☐	☐
Heart trouble	☐	☐
Migraine	☐	☐
Thyroid	☐	☐
Seasonal allergies	☐	☐
MRSA	☐	☐
HIV	☐	☐
Hepatitis C	☐	☐

9. Please list all medications you are taking, including any over-the-counter medications:

_____
_____
_____
_____

10. Please list any medications you are allergic to:

_____

11. Please list any major surgeries:

_____

12. Have you ever had any eye surgeries? Yes____No____

Please list_____
_____

13. Do you smoke?____Yes____No
If yes, how long?_____
Are you a former smoker?____Yes____No
When did you quit?_____

14. Do you use recreational drugs?____Yes____No

15. Do you use alcohol?____Yes____No

16.Primary care provider:

_____

17. Referring Doctor:

_____