# HEALTH HISTORY

**Name** _____ **Today's Date** _____

**Date of last exam** _____ **Name of eye doctor** _____

**Do you or any blood relatives have any of the following conditions?**

| | Yes | No | Indicate *Self* or *Family Member* |
|---|---|---|---|
| **Cataracts** | □ | □ | _____ |
| **Glaucoma** | □ | □ | _____ |
| **Retinal Detachment** | □ | □ | _____ |
| **Macular Degeneration** | □ | □ | _____ |
| **Lazy or Crossed Eye** | □ | □ | _____ |
| **Diabetes** | □ | □ | _____ |
| **High Blood Pressure** | □ | □ | _____ |
| **Thyroid** | □ | □ | _____ |

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**Have you had any of the following symptoms? Circle symptom & check. Explain if needed.**

| | Yes | No | |
|---|---|---|---|
| **Chronic fever, unexpected weight loss or gain, fatigue** | □ | □ | _____ |
| **Ear, nose, throat problems (sinus, dry mouth, hearing loss)** | □ | □ | _____ |
| **Heart or vascular problems (chest pain, irregular heartbeat, stroke)** | □ | □ | _____ |
| **Gastrointestinal problems (heartburn, Crohn's, colitis)** | □ | □ | _____ |
| **Urinary problems (pain or discomfort, bladder infections, STD)** | □ | □ | _____ |
| **Skin disease (rashes, eczema, psoriasis, rosacea)** | □ | □ | _____ |
| **Musculoskeletal problems (arthritis, swollen joints, muscle aches)** | □ | □ | _____ |
| **Neurological problems (numbness, paralysis, headaches)** | □ | □ | _____ |
| **Psychiatric problems (depression, anxiety)** | □ | □ | _____ |
| **Respiratory problems (asthma, emphysema, bronchitis)** | □ | □ | _____ |
| **Allergies/Immunologic (environmental, sneezing, hives, itching)** | □ | □ | _____ |
| **Females: Are you pregnant or nursing?** | □ | □ | _____ |

**List any other significant illnesses or surgeries:** _____

| | Yes | No | Please List: |
|---|---|---|---|
| **Do you have any allergies to medications?** | □ | □ | _____ |

**Please list current medications you are taking:**

_____

_____

_____

| | Yes | No | |
|---|---|---|---|
| **Do you drive?** | □ | □ | |
| **Do you use tobacco?** | □ | □ | **Amount?**_____ |
| **Do you consume alcohol?** | □ | □ | **Amount?**_____ |
| **Do you use illegal drugs?** | □ | □ | **List:**_____ |

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## Office Use Only – History Review

| Initials | Date | Initials | Date | Initials | Date | Initials | Date | Initials | Date |
|---|---|---|---|---|---|---|---|---|---|
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