

Health History Form

Please print, complete, and bring this form with you to your appointment.

Name: _____ Date: _____

Please check either "yes" or "no" for each of the following questions:

Medical Problems (Medical History and Review of Systems): Do you have any of the following?

<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Fever or weight loss</p> <p><input type="checkbox"/> <input type="checkbox"/> Migraines</p> <p><input type="checkbox"/> <input type="checkbox"/> Ear, nose, or throat problems _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Lung disease/Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney or urinary disease _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes: # of years _____</p> <p><input type="checkbox"/> <input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Ulcer or bowel disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Siezures</p> <p><input type="checkbox"/> <input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergies</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Skin rash</p> <p><input type="checkbox"/> <input type="checkbox"/> Neurologic problems _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Psychiatric disorders _____</p> <p><input type="checkbox"/> <input type="checkbox"/> High cholesterol</p> <p><input type="checkbox"/> <input type="checkbox"/> Carotid artery disease or stroke</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Bleeding disorders</p> <p><input type="checkbox"/> <input type="checkbox"/> Insulin: # of years _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Temporal arteritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Other _____</p> <p>_____</p> <p>_____</p>
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List any medications that you are taking, including eye drops:

Do you: Smoke Yes/Quit No **Drink Alcohol** Yes No **Drink Caffeine** Yes No

History of Eye Problems/Conditions: Have you had any of the following?

<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Cataracts</p> <p><input type="checkbox"/> <input type="checkbox"/> Retina disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Crossed/lazy eyes</p> <p><input type="checkbox"/> <input type="checkbox"/> Glaucoma</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Eye injury</p> <p><input type="checkbox"/> <input type="checkbox"/> Eye Surgery _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Corneal disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Other eye problems _____</p>
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Family History: Is there anyone in the family with any of the following diseases? If yes, what relation?

<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Blindness</p> <p><input type="checkbox"/> <input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> <input type="checkbox"/> Cataracts</p> <p><input type="checkbox"/> <input type="checkbox"/> Strabismus (crossed eye)</p> <p><input type="checkbox"/> <input type="checkbox"/> Amblyopia (lazy eye)</p>	<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Retinal disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Other serious eye disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Genetic disease (runs in the family)</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Other serious illnesses _____</p>
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Contact Lens Parameters:	Brand	Type	Sphere	Cyclinder (if Toric)
	Right Eye:	_____	_____	_____
	Left Eye:	_____	_____	_____