

HEALTH HISTORY FORM

Name: _____ Date: _____

Do you have, or have you had, any problems in the following areas?

	YES	NO	EXPLAIN
1. Ear, Nose, Mouth Throat			
2. Cardiovascular			
High Blood Pressure			
Heart Problems			
Stroke			
Carotid Artery Disease			
Other			
3. Respiratory			
Asthma			
Chronic Lung Disease			
Other			
4. Gastrointestinal			
5. Musculoskeletal			
Arthritis			
Other			
6. Skin			
7. Neurologic			
8. Endocrine			
Diabetes			
Thyroid			
Other			
9. Immunologic			
AIDS			
Other			
10. Cancer			
11. Eyes			
Cataracts			
Retina Disease			
Crossed Eyes			
Lazy Eye			
Iritis			
Corneal Disease			
Glaucoma			
Injury			
Surgery			
Other			

Any other pertinent health information:

II. Please list any allergies you have to medications. _____

III. What medications are you currently taking including eye drops? (If more than 5, please attach a list)

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IV. Please list any major surgeries you have had in the past.

V. Has any relative been treated for any of the following? Note relationship to patient:

F-Father **M**-Mother **S**-Sister **B**-Brother

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts _____	<input type="checkbox"/>	<input type="checkbox"/>	Heart _____
<input type="checkbox"/>	<input type="checkbox"/>	Cornea disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetic Retinopathy_____
<input type="checkbox"/>	<input type="checkbox"/>	Macular degeneration _____	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment____
<input type="checkbox"/>	<input type="checkbox"/>	Retinitis pigmentosa _____	<input type="checkbox"/>	<input type="checkbox"/>	Stroke _____
<input type="checkbox"/>	<input type="checkbox"/>	Other eye problems _____	<input type="checkbox"/>	<input type="checkbox"/>	

VI. Do you smoke? Yes (How much? _____) No
Do you drink alcohol? Yes (How much? _____) No

Dr. Initials

Date