

Name: _____

Date: _____

HEALTH HISTORY

Fill out this information to the best of your ability. Providing incorrect information can be dangerous to your health. Please inform the office when there are any change to your medical information.

Do you currently have the following conditions:

Sandy/gritty eyes	Y N	Glaucoma	Y N	Lazy Eye	Y N
Itching	Y N	Cataract	Y N	Crossed eyes	Y N
Burning	Y N	Macular Degeneration	Y N	Infection	Y N
Excess tearing	Y N	Glare/light sensitivity	Y N	Vision loss	Y N
Redness	Y N	Drooping eyelids	Y N	Other _____	

REVIEW OF SYSTEMS:

Good health lately Y N
Recent weight change Y N

Neurological

Headaches Y N
Seizures Y N
Paralysis Y N
Head injury Y N

Gastrointestinal

Loss of appetite Y N
Ulcers Y N
Nausea/vomiting Y N

Ears/Nose

Hearing loss Y N
Chronic Sinusitis Y N
Inner ear problems Y N
Nose bleeds Y N

Immunological

Lupus Y N
Sarcoidosis Y N
Ankylosing Spondilitis Y N
Sjogren's Syndrome Y N

Endocrine

Diabetes Y N
Frequent thirst Y N
Frequent hunger Y N
Frequent urination Y N
Thyroid condition Y N

Musculoskeletal

Rheumatoid arthritis Y N
Osteoarthritis Y N
Osteoporosis Y N
Cold extremities Y N
Difficulty Walking Y N
Muscle weakness Y N

Cardiovascular

Congestive Heart Failure Y N
Coronary Artery Disease Y N
Irregular heart beat Y N
Chest pain/angina Y N
Hypertension Y N
Stroke Y N

Skin

Rosacea Y N

Respiratory

Asthma Y N
Emphysema Y N
Bronchitis Y N
COPD Y N

Cancer

Breast Y N
Skin Y N
Lung Y N
Colon Y N
other _____

Blood/Lymphatic

Anemia Y N
Sickle Cell Y N
Hepatitis Y N
HIV Y N

Medication

Steroid Y N
Plaquenil Y N
Amniodarone Y N
Topamax Y N

Other medical conditions not listed: _____

Allergies to medication: _____

CURRENT MEDICATIONS: _____

Family Medical and Ocular Health History:

Diabetes	Y N	Cataracts	Y N	Lazy Eye	Y N
Hypertension	Y N	Glaucoma	Y N	Crossed Eyes	Y N
Stroke	Y N	Macular degeneration	Y N	Color blind	Y N
Cancer	Y N	Retinitis Pigmentosa	Y N	Blindness	Y N

Questions reviewed by doctor: _____ Date: _____