PATIENT HEALTH HISTORY

Date _____

Patient Name _____ DOB: _____ SSN _____

Personal Eye History:
Last eye examination_____Where?_____Dr.'s Name_____
Eye Surgeries? Yes or No Type_____ Date_____
Eye Injuries? Yes or No Describe_____ Date_____
Do you currently wear Eyeglasses? Yes or No Or Contact Lenses? Yes or No
What type of contact lenses do you wear? Brand_____
Prescription_____

Have you or anyone in your family been diagnosed with any of the following:

	Yourself		Family	
	Yes	No	Yes	No
Cataracts				
Glaucoma				
Macular Degeneration				
Lazy Eye (Amblyopia)				
Blindness				
High Blood Pressure				
Heart Attack				
Asthma / Emphysema				
Colitis				
Hepatitis				
Kidney Disease				
Arthritis				
Migraines				
Stroke				
Seizures				
Diabetes				
Thyroid Disease				
Sickle Cell Anemia				
Leukemia				
Shingles				
AIDS / HIV				
Cancer				
Lupus				
Other _____				

(TURN OVER TO COMPLETE)

Who is your Primary Care Doctor?

Dr.'s Name _____ Location _____

List of Current Medications

_____
_____
_____
_____
_____
_____
_____
_____

List of Allergies (seasonal or drug)

_____
_____
_____
_____
_____
_____
_____
_____

Please list below any additional information that might be pertinent to your care:

_____
_____
_____
_____
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_____
_____
_____

FOR OFFICE USE ONLY

Reviewed By: _____ Date: _____

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