PATIENT HEALTH HISTORY

Patient Name _____

Last Eye Exam Date _____ With whom?_____ Primary Care Dr. _____
Eye Surgeries? Yes No Type_____ Date_____
Eye Injuries? Yes No Describe_____ Date_____
What brand of contact lenses do you wear? _____Do you sleep with them in? _____

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)				
High Blood Pressure				
Heart Attack				
Asthma / Emphysema				
Hepatitis				
Kidney Disease				
Arthritis				
Migraines				
Stroke				
Seizures				
Diabetes				
Thyroid Disease				
Shingles				
AIDS / HIV				
Cancer				
Other _____				

List of Current Medications: _____
_____
_____
_____
_____

List of Current Allergies: _____
_____
_____

Do you have any specific concerns about your eyes today?

_____
_____
_____
_____