HEALTH HISTORY FORM

		DATE:
Name:		Family Physician:
Age:	Occupation:	Last Eye Exam:

Do you have any of following medical problems?	Self History	Family History	If yes please explain:
Ears,Nose,Throat(sinus,sore throat)	Y/N	Y/N	
Heart (Chest pain,irregular beat)	Y/N	Y/N	
Breathing Problems (short breath)	Y/N	Y/N	
GI (diarrhea,vomiting,stomache pain)	Y/N	Y/N	
Kidney Disease(pain, blood in urine)	Y/N	Y/N	
Neurological (seizure, stroke, weak)	Y/N	Y/N	
Skin Problems	Y/N	Y/N	
Arthritis (joint aches or pains)	Y/N	Y/N	
Psychiatric Problems	Y/N	Y/N	
Diabetes	Y/N	Y/N	
Migraine Headaches	Y/N	Y/N	
Asthma	Y/N	Y/N	
Bleeding Problems	Y/N	Y/N	
Anemia	Y/N	Y/N	
Cancer	Y/N	Y/N	
Thyroid Problems	Y/N	Y/N	
High Blood Pressure	Y/N	Y/N	
HIV/Aids/Hepatitis	Y/N	Y/N	
Other Medical Problems:			

Eye History	Self	Family	If yes please explain
Glaucoma	Y/N	Y/N	
Diabetes	Y/N	Y/N	
Retinal Problems	Y/N	Y/N	
Lazy Eye	Y/N	Y/N	
Corneal Problems	Y/N	Y/N	
Eye Injury	Y/N	Y/N	
Macular Degeneration	Y/N	Y/N	
Cataracts	Y/N	Y/N	
Eye Muscle Surgery	Y/N	Y/N	
Other	Y/N	Y/N	

All past surgeries:

Any problems with anesthesia: Yes No

Female Patients: Are you currently pregnant? Yes No

Social History

Do you smoke?	Y/N	Do you drive?	Y/N
Do you drink Alcohol?	Y/N		

Medications
Non Prescription Drugs
Allergies to medicines or foods:
Are you taking any: Asprin, Motrin, Anticoagulants

Patient Signature:_____ Date:_____

Physician Signature:_____ Date:_____