HEALTH HISTORY

PATIENT NAME: _____ **DATE:**_____

Your Medical Doctor_____ **Allergies:**_____

Have you ever been treated for any of the following medical conditions?

Yes	No		Yes	No	
€	€	Diabetes: # of years_____Taking Insulin?_____	€	€	Carotid Artery Disease_____
€	€	Arthritis: Osteo___ Rheumatoid___Other_____	€	€	Temporal Arteritis__-_____
€	€	Lung disease: Asthma__TB__Other_____	€	€	Head or Spinal Injury_____
€	€	Kidney Disease: Stones___Other_____	€	€	Seizures, Convulsions, Tremors, or Fainting____
€	€	Thyroid Disease:Type_____	€	€	Hormone Replacement_____
€	€	Neurological Disease_____	€	€	(Women) Are you pregnant or nursing?_____
€	€	Headaches or Migraines_____	€	€	Immune Disease:Leukemia__Lupus_HIV/AIDS_
€	€	Cancer -Type:_____			Lymph Node Swelling__Other_____
€	€	Neurologic Disease_____	€	€	Stroke_____
€	€	Heart Disease:Heart Attack__Angina__ Bypass_____	€	€	High Blood Pressure: # of years_____
		Heart Failure____Other_____	€	€	Blood Disorder:Anemia__Other_____
€	€	GI Disorder: Ulcer__Hepatitis__Other_____	€	€	Serious Trauma_____
€	€	Any other Disease/Disorder Not Listed:_____			

Your Eye History: Have you ever had any eye disease? Yes € No € If YES, please check all that apply.

___Glaucoma ___Cataracts ___Crossed eyes/strabismus ___Macular degeneration
___Iritis ___Eye Injury:_____ ___Dry eyes ___Lazy eye/amblyopia
___Blepharitis ___Other retinal disease:_____ ___Corneal Disease:_____

Have you ever had eye surgery? Yes € No € If YES, list:

Surgery	Eye	Date	Surgery	Eye	Date	Surgery	Eye	Date

Have you ever had other surgery? Yes € No € If YES, list:?

Surgery	Date	Surgery	Date	Surgery	Date

Do you take any medications (including eye medications)? Yes € No € If YES, please list:_____

_____

_____

_____

Social History

Are you or have you ever been regularly employed? Yes € No € If YES, what kind of work do/did you do?_____

How much alcohol do you drink? (type,# per day or week)_____

Do you live alone? Yes € No €

Have you ever smoked regularly? Yes € No € Do you smoke now ? Yes € No € If no, when did you stop?_____

How much do/did you smoke?_____For how many years?_____

Date Reviewed & Updated_____	**Tech Signature**_____	**Date Reviewed & Updated**_____	**Tech Signature**_____
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