# PATIENT HEALTH HISTORY

Name:________________________________________ DOB:______________________________

**Date:**________________________ **Family Doctor:**____________________________________________

**LIST ALL *EYE* MEDICATION YOU ARE USING, INCLUDING OVER-THE COUNTER:**

| MEDICATION NAME | STRENGTH | HOW OFTEN |
|---|---|---|
| | | |
| | | |
| | | |

**CIRCLE ANY OF THE FOLLOWING EYE CONDITIONS THAT YOU HAVE BEEN DIAGNOSED WITH:**

| | | |
|---|---|---|
| Cataracts | Floaters | Myopia (near-sightedness) |
| Glaucoma | Retinal tear or detachment | Hyperopia (far-sightedness) |
| Dry eye syndrome | Lazy eye | Astigmatism |

Other_____________________________________________________________________________________

**CIRCLE NO/YES IF YOU HAVE BEEN DIAGNOSED WITH ANY OF THESE HEALTH CONDITIONS:**

| | | |
|---|---|---|
| Heart Problems | No | Yes__________________________________ |
| High Blood Pressure | No | Yes__________________________________ |
| Ear/Nose/Throat issues | No | Yes__________________________________ |
| Lung/Breathing issues | No | Yes__________________________________ |
| Stomach/Bowel issues | No | Yes__________________________________ |
| Reproductive/Urinary Tract issues | No | Yes__________________________________ |
| Skin issues | No | Yes__________________________________ |
| Muscle/Skeletal issues | No | Yes__________________________________ |
| Brain/Neurological issues | No | Yes__________________________________ |
| Allergy/Immunity issues | No | Yes__________________________________ |
| Diabetes | No | Yes – type I or II?__________________________ |
| Thyroid disease | No | Yes__________________________________ |
| Cancer | No | Yes__________________________________ |

**LIST ANY *EYE* SURGERIES YOU HAVE HAD**:

| SURGERY | DATE | DOCTOR |
|---|---|---|
| | | |
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| | | |

□ check box if more on back

**LIST ANY *OTHER* SURGERIES YOU HAVE HAD:**

| SURGERY | DATE |
|---|---|
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□ check box if more on back

**INDICATE IF ANY OF YOUR *BLOOD* RELATIVES HAVE HAD ANY OF THE FOLLOWING:**

| CONDITION | NO | YES | RELATION |
|---|---|---|---|
| Blindness | | | |
| Cataracts | | | |
| Glaucoma | | | |
| Macular Degeneration | | | |
| Retinal problems | | | |
| Other eye disease | | | |
| Cancer | | | |
| Diabetes | | | |
| Heart Disease | | | |
| High Blood Pressure | | | |
| ADOPTED – Family History Unknown | | | |

**CIRCLE FREQUENCY FOR EACH SOCIAL HISTORY ITEM BELOW:**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Alcohol use** | Never | In past, but quit | Yes,on occasion | Yes, moderate | Yes,daily | |
| **Tobacco use** | Never | In past, but quit | Yes, on occasion | Yes, < 1 pack/day | Yes, about 1 pack/day | Yes, > 1 pack/day |
| **Medical Marijuana** | Never | In past, but quit | Yes, on occasion | Yes, frequently | | |
| **Illegal Drugs** | Never | In past, but quit | Yes, on occasion | Yes, frequently | | |

**LIST ANY DRUGS THAT YOU ARE ALLERGIC TO:** □ check here if NO drug allergies

____________________________________________________________

____________________________________________________________

**LIST ALL MEDICATIONS (NON-OCULAR) YOU ARE TAKING, INCLUDING OVER-THE-COUNTER:**

| MEDICATION NAME | STRENGTH | HOW OFTEN |
|---|---|---|
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□ check box if more on back

**PHARMACY NAME:**______________________________ **CITY:**____________________