HEALTH HISTORY

Yes	No		Yes	No	
☐	☐	Asthma _____	☐	☐	Head or Spinal Injuries _____
☐	☐	Kidney Disease _____	☐	☐	Seizures, Convulsions, or Fainting _____
☐	☐	Tuberculosis _____	☐	☐	Extensive Confinement by illness or injury _____
☐	☐	Diabetes IDDM/Type II ____ # of yrs ____	☐	☐	Are you allergic to latex? _____
☐	☐	Insulin _____	☐	☐	Suffering from any other disease _____
☐	☐	Migraines _____	☐	☐	Carotid Artary Disease _____
☐	☐	Psychiatric Disorder _____	☐	☐	Permanent Defect from Illness, Disease or injury _____
☐	☐	Any nervous disorder _____	☐	☐	(Women) Are you Pregnant? _____
☐	☐	Heart Disease _____	☐	☐	High Blood Pressure _____ # of yrs _____
☐	☐	Ulcer _____	☐	☐	Stroke _____
☐	☐	Sickle Cell Anemia _____	☐	☐	HIV _____
☐	☐	Do you Smoke? _____	☐	☐	Are your immunizations current? _____
☐	☐	Do you Drink? _____	☐	☐	Cancer _____
☐	☐	Within the last twelve (12) months have you taken any illegal substances? _____			

Please List All Medications You Are Currently **TAKING:**	Please **List** all Medications You Are Allergic to **AND REACTIONS**

YOUR OCULAR HISTORY (Have you been diagnosed with any of the following in the past year?)

Cataract Surgery (Date of Surgery) Right Left _____

Retina Surgery (Date of Surgery) Right Left _____

Explanation of Eye Injury: Right Left _____

Yes	No	
☐	☐	Cornea Disease _____
☐	☐	Glaucoma _____
☐	☐	Injury _____
☐	☐	Cataracts _____
☐	☐	Retina Disease _____
☐	☐	Crossed Eyes _____
☐	☐	Iris _____
☐	☐	Other Eye Disorders _____

YOUR SURGERY HISTORY (Please include Date & Type)

FAMILY HISTORY (Has anyone in your family (blood relative) had any of the following?
(RELATION TO PATIENT) F - Father M - Mother S - Sister B - Brother
GF - Grandfather GM - Grandmother U - Uncle A - Aunt

Yes	No		Yes	No	
☐	☐	Glaucoma _____	☐	☐	Diabetes IDDM/Type II _____
☐	☐	Cataracts _____	☐	☐	Heart _____
☐	☐	Cornea Disease _____	☐	☐	Diabetic Retinopathy _____
☐	☐	Macular Degeneration _____	☐	☐	Retinal Detachment _____
☐	☐	Retinitis Pigmentoso _____	☐	☐	Stroke _____
☐	☐	Other Eye Problems _____	☐	☐	Cancer _____

Tech Signature _____ Date _____

Patient Name _____ Date _____