

Health History

Eye Health

Last Name _____ First Name _____ MI ____ DOB ____ / ____ / ____

Do you wear glasses? Yes No Date of last eye exam ____ / ____ / ____
 All the time ____ Occasionally ____ Reading ____ Driving ____ TV ____ Other ____
 Do you wear contact lenses? Yes No Brand: _____ Solution: _____

Do you have or have you been treated for any of the conditions below?

Blood Shot Eyes	Yes	No	Dry Eyes	Yes	No	Light Sensitivity/Glare	Yes	No	See Halos or Flashes	Yes	No
Blurred Vision	Yes	No	Eye Injuries	Yes	No	Loss of Vision	Yes	No	Watering Eyes	Yes	No
Burning Eyes	Yes	No	Floater or Spots	Yes	No	Poor Night Vision	Yes	No	Itching Eyes	Yes	No
Double Vision	Yes	No	Headaches	Yes	No	Red Eyes	Yes	No	Other _____		

Health History

Family Doctor: _____ Last visit ____ / ____ / ____ Date of last tetanus shot ____ / ____ / ____

Please **circle** Yes or No to indicate if you or a family member has had any of the following:

	Yourself		Family Member		Relationship To Patient		Yourself		Family Member		Relationship To Patient
AIDS/HIV	Yes	No	Yes	No	_____	Kidney Disease	Yes	No	Yes	No	_____
Arthritis	Yes	No	Yes	No	_____	Lazy Eye	Yes	No	Yes	No	_____
Asthma	Yes	No	Yes	No	_____	Lupus	Yes	No	Yes	No	_____
Bleeding	Yes	No	Yes	No	_____	Migraine Headaches	Yes	No	Yes	No	_____
Blindness	Yes	No	Yes	No	_____	Poor Color Vision	Yes	No	Yes	No	_____
Cancer	Yes	No	Yes	No	_____	Retinal Disease	Yes	No	Yes	No	_____
Cataracts	Yes	No	Yes	No	_____	Rheumatic Fever	Yes	No	Yes	No	_____
Drug Sensitivity	Yes	No	Yes	No	_____	Shingles	Yes	No	Yes	No	_____
Emphysema	Yes	No	Yes	No	_____	Skin Conditions	Yes	No	Yes	No	_____
Epilepsy	Yes	No	Yes	No	_____	Stroke	Yes	No	Yes	No	_____
Glaucoma	Yes	No	Yes	No	_____	Thyroid Conditions	Yes	No	Yes	No	_____
Hay Fever	Yes	No	Yes	No	_____	Tuberculosis	Yes	No	Yes	No	_____
Heart Condition	Yes	No	Yes	No	_____	Turned Eye	Yes	No	Yes	No	_____
Hepatitis	Yes	No	Yes	No	_____	Tobacco Use	Yes	No	Yes	No	_____
High Blood Pressure	Yes	No	Yes	No	_____	Alcohol Use	Yes	No	Yes	No	_____
Diabetes	Yes	No	Yes	No	_____	Other Health Conditions _____					
If yes on self: Type _____ Diagnosis Date ____ / ____ / ____											

Medications: (including eye drops) _____

Allergies to medications: _____

Operations: (including eye surgeries) _____

Today's date _____ Reviewed by: _____