HEALTH HISTORY

PATIENT NAME_____ **DATE**_____

Yes	No		Yes	No	
☐	☐	Lung Disease -Type:_____	☐	☐	Head or Spinal Injuries _____
☐	☐	Kidney Disease:_____	☐	☐	Seizures, Convulsions, Fainting_____
☐	☐	Arthritis:_____	☐	☐	Temporal Arteritis_____
☐	☐	Diabetes_____ #of Yrs____	☐	☐	Carotid Artery Disease _____
☐	☐	Neurological Disease:_____	☐	☐	(Women) Are you pregnant or nursing? _____
☐	☐	Migraines _____	☐	☐	Stroke_____
☐	☐	Psychiatric Disorder_____	☐	☐	HIV/AIDS _____# of Yrs _____
☐	☐	Nervous Disorder _____	☐	☐	Extensive Confinement from Illness or Injury_____
☐	☐	Heart Disease _____	☐	☐	Permanent Defect from Illness, Disease or Injury _____
☐	☐	Gastrointestinal Disease – Type: _____	☐	☐	Suffering from any other Disease _____
☐	☐	High Blood Pressure:_____ #of Yrs____	☐	☐	Do You Smoke? #___Packs per ☐ Day ☐ Week ☐ Month
☐	☐	Scarring / Keloids	☐	☐	Do You Drink? # ___per ☐Day ☐Week ☐Month
☐	☐	Are You Allergic to Latex, Rubber (Balloons)?	☐	☐	Are You Allergic to Bananas, Pears Avocado, Chestnuts?
YOUR MEDICAL DOCTOR_____			☐	☐	Do You Live Alone?

Please List All Medications You Are Currently Taking:

_____

_____

_____

_____

Please List All Medication Allergies:

_____

_____

_____

_____

Have You Been Diagnosed With or Treated for Any of the Following:

Yes	No		Yes	No	
☐	☐	Cataracts	☐	☐	Corneal Disease
☐	☐	Crosses Eyes	☐	☐	Glaucoma
☐	☐	Retinal Disease _____	☐	☐	Iritis
☐	☐	Injury _____	☐	☐	Other Eye Disorders: _____

Cataract Surgery Date: _____Right Eye _____Left Eye

Do You Have a Lens Implant? Yes ☐ No ☐

Other Eye Surgery/Date: Right Eye_____ Left Eye_____

Type of Eye Injury (if any): _____

Has any Family Member (Mother, Father, Sisters or Brothers) Been Treated for the Following?

Yes	No		Yes	No	
☐	☐	Glaucoma _____	☐	☐	Retinal Detachment _____
☐	☐	Cataracts _____	☐	☐	Corneal Disease _____
☐	☐	Macular Degeneration _____	☐	☐	Retinitis Pigmentosa _____
☐	☐	Diabetic Retinopathy _____	☐	☐	Other Eye Problems _____
☐	☐	Diabetes _____	☐	☐	Heart Disease _____
☐	☐	Stroke _____	☐	☐	Other Health Conditions _____

Please List any Previous Surgeries and their Date:

_____ _____

_____ _____

Tech. Signature: _____