Name ____ **Date** ____________________________

Health History

Reason for seeing Doctor today ____

Yes	No		Yes	No	
____	____	Asthma	____	____	Head or Spinal Injuries
____	____	Kidney Disease	____	____	Seizures, Convulsion, or fainting
____	____	Tuberculosis	____	____	Extensive confinement by illness or injury
____	____	Diabetes	____	____	Any other nervous disorder
____	____	Migraines	____	____	Suffering from any other disease
____	____	Psychiatric Disorder	____	____	Permanent defect from illness, disease or injury
____	____	Heart Disease	____	____	High Blood Pressure
____	____	Ulcer	____	____	Other Diagnosed Heath Problems

If answer to any one of the above is yes, explain: ____
____
____

Please List All Medication You Are Currently Taking

____
____
____
____
____
____
____

Please List All Medications You Are Allergic To

____
____
____
____
____
____
____

Your Ocular History (have you been diagnosed with any of the following in the past?)

Yes	No		Yes	No	
____	____	Cataracts	____	____	Cornea
____	____	Retina	____	____	Other Eye Disorders:
____	____	Glaucoma			1. ______________________________________
____	____	Crossed Eyes			2. ______________________________________

Family History (Has anyone in your family (blood relative) had any of the following?)

Yes	No		Yes	No	
____	____	Glaucoma	____	____	Diabetes
____	____	Cataracts	____	____	Heart
____	____	Other Eye Problems:	____	____	Other General Health Problems:
		1. ___________________________			1. ___________________________
		2. ___________________________			2. ___________________________

Surgical History (All Surgeries – including eyes)

____
____
____
____
____
____