

HEALTH HISTORY

Patient's Name _____

Place a mark on "Yes" or "No"

	Yourself		Family Members			Yourself		Family Members	
AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis (Type_____)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lazy Eye	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lupas	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Poor Color Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Retinal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drug Sensitivity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin Conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Turned Eye	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you pregnant?_____	Number of children_____			
Heart Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tobacco use_____	Alcohol use_____			

EYE HEALTH HISTORY

Physician's Name _____	Place a mark on "Yes" or "No" to indicate if you have had any of the following:					
Date of last visit _____	Bloodshot Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Floaters or Spots	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last eye exam? _____	Blurred Vision – Distance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name of doctor _____	Blurred Vision – Near	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No	Burning Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Itching Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> All the time <input type="checkbox"/> Occasionally	Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Light Sensitive	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Reading <input type="checkbox"/> Driving <input type="checkbox"/> TV	Color Vision, Poor	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Loss of Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you wear contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No	Crossed Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Type_____ Hours/Day_____	Discharge from Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Night Vision Poor	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Describe any problems you have with your contacts _____	Dizzy Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Red Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	Double Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seeing Halos	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Dry Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seeing Flashes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Eye Infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Temporary Loss of Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Eye Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Twitching Eyelid	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Eye Strain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vision Poor	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Fainting Spells, Blackouts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Watering Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No