



Health History

Date _____

Name _____

Age _____

Reason for today's exam _____

Date of last exam _____ Name of eye doctor _____

Do you have a history of the following?

Diabetes Thyroid Disease Arthritis
 High Blood Pressure Heart Disease Sinus/Allergy
 Stroke Lung Disease Other _____

Have you ever had any of the following conditions involving your eyes?

Eye Surgery Sensitivity to Light Eye Infection
 Eye Injury Spots or Floaters Double Vision
 Severe Pain Eye Strain Poor Distance Vision
 Headaches Poor Near Vision Burning, Itching, Watering
 Cataracts Glaucoma Diabetic Retinopathy
 Blindness Lazy Eye Macular Degeneration

Do you have immediate family members treated for the following?

Diabetes High Blood Pressure Heart / Lung Disease
 Cataract Glaucoma Macular Degeneration
 Other _____

Do you use cigarettes/tobacco? _____ Alcohol? _____ Other Substance? _____

Please list all medications and eye drops you are currently taking _____

Are you allergic to any medications? Please list _____

When do you wear your glasses?

All the Time Reading/Near Work Work Safety
 Distance Only Computer Work Other _____

Have you ever worn contact lenses? Yes No

Are you interested in wearing contact lenses? Yes No

Are you interested in refractive surgery (LASIK)? Yes No

Do you work at a computer or video display terminal? Yes No

What hobbies or sports do you participate in? _____