GENERAL EYE & HEALTH HISTORY

Name:______________________________ Birthday: ______________ Date:___________

Glasses and Contact Lenses: Do you **CURRENTLY** wear glasses or contact lenses?

_____ Glasses for distance _____ Glasses for near ______ Soft Contact Lenses _____ Rigid Contact Lenses

Eye Diseases: Do you **NOW**, or have you **EVER** had any of the following eye diseases?

	YES	NO	FAMILY HISTORY			YES	NO	FAMILY HISTORY	
1	___	___	________	Cataract	6	___	___	________	Crossed Eye
2	___	___	________	Glaucoma	7	___	___	________	Lazy Eye
3	___	___	________	Detached Retina	8	___	___	________	Injury
4	___	___	________	Diabetic Retinopathy	9	___	___	________	Blindness
5	___	___	________	Macular Degeneration	10	___	___	________	Other

Surgery and Laser: Please list all eye/eyelid **SURGERIES** and **LASERS** that you have had.

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____

Eye Medications: Please list all medicines that you are currently using for you eyes?

Medication	Eye	Frequency

Current Problems: Do you **CURRENTLY** have any of the following problems?

	YES	NO			YES	NO	
1	______	_____	Fever / Weight Loss	13	_______	______	Joint / Muscle Pain
2	______	_____	Ears / Mouth / Nose / Throat	14	_______	______	Skin
3	______	_____	Sinus Problems	15	_______	______	Headache
4	______	_____	High Blood Pressure	16	_______	______	Stroke / Other Neurological Disease
5	______	_____	Irregular Heart Beat	17	_______	______	Depression or Psychiatric Problems
6	______	_____	Angina / Heart Attack	18	_______	______	Dizziness / Fainting
7	______	_____	Other Heart Disease	19	_______	______	Blood Disorder / Prolonged Bleeding
8	______	_____	Asthma or Emphysema	20	_______	______	HIV / AIDS
9	______	_____	Other Lung Disease	21	_______	______	Seasonal Allergies
10	______	_____	Diabetes / Thyroid	22	_______	______	Unusual Reactions to Anesthetics
11	______	_____	Stomach / Intestinal Problem	23	_______	______	Smoking
12	______	_____	Kidney / Urinary / Genital Disease	24	_______	______	Other

Medications: Please list all medicines including aspirin that you take (except eye medications).

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Allergies: Please list all allergies to **MEDICINES** that you have and the reaction it causes.

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Family History: Please list all medical conditions that affect your parents, siblings or children.

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Family Physician ___________________________ **City** _______________ **Last Seen** __________

Patient Signature ___________________________ **Date** ______________ **Dr Reviewed** ________