Health History Form

Name: _____ DOB: _____ Today's Date: _____

Date of last physical exam: _____ Primary Care Physician: _____

Date of last eye exam: _____ Previous Optometrist: _____

Medical History

Have you ever been diagnosed with:	Self	Relative	Relation
Diabetes	☐	☐	
High Blood Pressure	☐	☐	
High Cholesterol	☐	☐	
Thyriod Condition	☐	☐	
Heart Disease	☐	☐	
Heart Attack	☐	☐	
Stroke	☐	☐	
Arthritis	☐	☐	
Cancer	☐	☐	
Asthma	☐	☐	
Emphysema	☐	☐	
Allergies	☐	☐	
Kidney Disease	☐	☐	
Liver Diease	☐	☐	
Epilepsy/Seizures	☐	☐	
Migraines	☐	☐	
Multiple Sclerosis	☐	☐	
Blood Condition	☐	☐	
Autoimmune Condition	☐	☐	
Other (please list):	☐	☐	

I am adopted, and my family history is unknown. ☐

Have you ever been diagnosed with or exposed to: ☐ HIV/AIDS ☐ Hepatitis ☐ Other sexually-transmitted disease

Have you had herpes zoster/shingles? ☐ Yes ☐ No Are you currently pregnant and/or nursing? ☐ Yes ☐ No

Please list any major surgeries you have had: _____

_____

Please list any medications you take, including over-the-counter medications: _____

_____

_____

Please list any allergies you have to medications, food, materials, dyes, etc.: _____

_____

Ocular History

Have you ever been diagnosed with:	Self	Relative	Relation
Glaucoma	☐	☐	
Cataracts	☐	☐	
Macular Degeneration	☐	☐	
Diabetic Retinopathy	☐	☐	
Retinal Detachment	☐	☐	
Retinal Disease	☐	☐	
Amblyopia/Lazy Eye	☐	☐	
Strabismus/Eye Turn	☐	☐	
Dry Eye Syndrome	☐	☐	
Keratoconus	☐	☐	
Blindness	☐	☐	
Other (please list):	☐	☐	

Name: _____

Please list any eye drops you use, including over-the-counter: _____

_____

Do you wear glasses? ◻ Yes ◻ No If so, do you wear them full-time or only sometimes? ◻ Full-time ◻ Sometimes

Do you wear contact lenses? ◻ Yes ◻ No If so, what brand do you wear? _____

Are you wearing contacts today? ◻ Yes ◻ No How often do you replace your lenses? _____

Have you had LASIK, PRK, or any other refractive surgery? ◻ Yes ◻ No If so, when was your surgery? _____

Have you had cataract surgery? ◻ Yes ◻ No If so, when was your surgery? _____

Social History

Do you drive? ◻ Yes ◻ No Do you have visual difficulty while driving? ◻ Yes ◻ No If so, please explain:_____

_____

How many hours per day do you work on a computer? _____ Do you have multiple monitors? ◻ Yes ◻ No

Do you experience eye strain or fatigue at the end of the day? ◻ Yes ◻ No If so, how often? _____

Do you participate in sports and/or hobbies that require eye protection? ◻ Yes ◻ No

Do you use tobacco products? ◻ Yes ◻ No If so, what type and how often? _____

Do you use drink alcohol? ◻ Yes ◻ No If so, what type and how often? _____

Do you use illicit drugs? ◻ Yes ◻ No If so, what type and how often? _____

Review of Systems

Are you currently experiencing problems with any of the following (please circle):

Eyes: burning, itching, redness, dryness, watering, flashes of light, floaters Other: _____

Allergy: excessive itching, reaction to food, cream or medication Other: _____

Cardiovascular: chest pains or stiffness, heart murmur or palpitations Other: _____

Constitutional: fever, fatigue, weight loss, weight gain Other: _____

Endocrine: heat or cold intolerance, excessive thirst, excessive urination Other: _____

Gastorintestinal: loss of appetite, constipation, diarrhea, heartburn, nausea Other: _____

Genitourinary: urinary incontinence, frequent urinary infections Other: _____

Head: chronic cough, dry mouth, hearing loss, ringing in ears, frequent sinus infections Other: _____

Hematologic/Lymphatic: bleed or bruise easily, swollen lymph nodes, nose bleeds Other: _____

Immunologic: history of chicken pox, lyme disease, sarcoidosis, or tuberculosis Other: _____

Integumentary/Skin: changes to nails, eczema, hair loss, skin rashes or sores Other: _____

Musculoskeletal: back pain, joint pain or swelling, muscle pain or weakness Other: _____

Neurological: blackouts, memory loss, numbness, seizures, tingling, tremors Other: _____

Psychiatric: hallucinations, confusion, depression, mood swings, nervousness Other: _____

Respiratory: coughing, shortness of breath, wheezing Other: _____