HEALTH HISTORY FORM

Name:___________________________________ Date:___________________

Do you have, or have you had, any problems in the following areas?

	YES	NO	EXPLAIN
1. Ear, Nose, Mouth Throat			
2. Cardiovascular			
High Blood Pressure			
Heart Problems			
Stroke			
Carotid Artery Disease			
Other			
3. Respiratory			
Asthma			
Chronic Lung Disease			
Other			
4. Gastrointestinal			
5. Musculoskeletal			
Arthritis			
Other			
6. Skin			
7. Neurologic			
8. Endocrine			
Diabetes			
Thyroid			
Other			
9. Immunologic			
AIDS			
Other			
10. Cancer			
11. Eyes			
Cataracts			
Retina Disease			
Crossed Eyes			
Lazy Eye			
Iritis			
Corneal Disease			
Glaucoma			
Injury			
Surgery			
Other			

Any other pertinent health information:
II. Please list any allergies you have to medications. ______________________
____
____

III. What medications are you currently taking including eye drops? (If more than 5, please attach a list)

Name	Dose	Frequency

IV. Please list any major surgeries you have had in the past.
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____
____

V. Has any relative been treated for any of the following? Note relationship to patient:

F-Father **M**-Mother **S**-Sister **B**-Brother

YES	NO		YES	NO	
		Glaucoma _____			Diabetes ____
		Cataracts _____			Heart _____
		Cornea disease _____			Diabetic Retinopathy____
		Macular degeneration _____			Retinal Detachment___
		Retinitis pigmentosa _____			Stroke _____
		Other eye problems _____			

VI. Do you smoke? Yes (How much? ________________) No
Do you drink alcohol? Yes (How much? _________________) No

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Dr. Initials Date