EYE AND GENERAL HEALTH HISTORY

Please check yes or no and circle if there is more than one

Yes	No		Yes	No	
( )	( )	Asthma, Bronchitis, Emphysema	( )	( )	Sickle Cell Anemia
( )	( )	Kidney Disease	( )	( )	Head or Spinal Injuries
( )	( )	Tuberculosis	( )	( )	Seizures, Convulsions, Fainting
( )	( )	Diabetes…if yes # of years___	( )	( )	Stroke
( )	( )	Insulin …if yes # of years___	( )	( )	Permanent Defect from Illness, Disease, or Injury
( )	( )	Migraines	( )	( )	(Women) Are You Pregnant?
( )	( )	Psychiatric Disorder	( )	( )	High Blood Pressure
( )	( )	Any Nervous Disorder	( )	( )	HIV/ AIDS
( )	( )	Heart Attack or Heart Failure	( )	( )	Suffering from other Disease
( )	( )	Chest Pain	( )	( )	Other Diagnosed Health Problems_____
( )	( )	Congestive Heart Failure	( )	( )	Arthritis
( )	( )	Ulcer, Heartburn	( )	( )	Cancer (List Type):_____
( )	( )	Thyroid Disorder	( )	( )	Lymphoma

Please check all Surgeries you have had:

Tonsillectomy___ Heart By-Pass___ Hysterectomy___ C-section___ Stint___ Gall Bladder___ Knee___ Hip___
Mastectomy___ Appendectomy___ Mole Removal___ Plastic Surgery___ Endoscopy___ Back___ Transplant___
Dental Surgery___ Hernia Repair___
Other: Please List_____
Dates of Surgery: _____

Please List all Medications Currently Taking: **Please List Medications You Are ALLERGIC To:**

_____ _____ _____
_____ _____ _____
_____ _____ _____

Ocular History (Have you been diagnosed with any of the following in the past?)

Yes	No		Yes	No		Yes	No	
( )	( )	Cataracts	( )	( )	Crossed Eyes	( )	( )	Cornea Disease (Front Surface of Eye)
( )	( )	Retina Disease	( )	( )	Iritis (Red Inflamed Eye)	( )	( )	Injury_____
( )	( )	Glaucoma	( )	( )	Other Eye Disorder: _____			

Cataracts (Date of Surgery): Right_____ Left_____
Do you have a lens implant? Yes ( ) No ( )
Retina Surgery (Date of Surgery): Right_____ Left_____
Explanation of Eye Injury: _____

Family History (Blood Relatives Only: Mark Relation, i.e. Mother, Father, Grandparent, Aunt)

Yes	No		Yes	No	
( )	( )	Glaucoma_____	( )	( )	Diabetes IDDM/ Type II_____
( )	( )	Cataracts_____	( )	( )	Heart Attack_____
( )	( )	Cornea Disease_____	( )	( )	Diabetic Retinopathy_____
( )	( )	Macular Degeneration_____	( )	( )	Retinal Detachment_____
( )	( )	Retinitis Pigmentosa _____	( )	( )	Stroke_____
( )	( )	Blindness_____	( )	( )	Tuberculosis_____
( )	( )	Cancer_____	( )	( )	High Blood Pressure_____
( )	( )	Other General Medical Problems: _____			

Eyes:

Loss of vision: Near/Far ( ) Yes ( ) No Floaters ( ) Yes ( ) No **Eye Pain ( ) Yes ( ) No**
Burning ( ) Yes ( ) No Blurred or Distorted Vision ( ) Yes ( ) No **Flashes of Light ( ) Yes ( ) No**
Loss of Side Vision ( ) Yes ( ) No **Glare/ Sensitivity to light ( ) Yes ( ) No**
Do you have problems with night vision? ( ) Yes ( ) No