Health History

405 S. 30th Street Corner of 30th and Garfield Laramie, WY 82070

Name:_____ Date: _____

What brings you into our office today?_____

Ocular History

Do you currently wear glasses? Y N If yes, how often? _____

Do you currently wear contacts? Y N If yes, how often? _____

Do you have any of the following conditions or diagnoses?

1.	Macular Degeneration	Y	N	9.	Retinopathy	Y	N
2.	Amblyopia (Lazy Eye)	Y	N	10.	Tear Film Insufficiency	Y	N
3.	Cataracts	Y	N	11.	Vitreous Flashes	Y	N
4.	Glaucoma	Y	N	12.	Vitreous Floaters	Y	N
5.	Hypermetropia	Y	N	13.	Eye Turn (Strabismus)	Y	N
6.	Mypoia	Y	N	14.	Blindness	Y	N
7.	Presbyopia	Y	N	15.	Retinal Defect	Y	N
8.	Pseudophakia	Y	N	16.	Keratoconus	Y	N

Other Eye Injury or Disease Please Specify _____

Health History

Do you have any allergies? Y N If yes, please specify? _____

Do you have any allergies to medications? Y N

If yes, please specify the medication name and reaction _____

Do you have any of the following conditions or diagnoses?

1.	Anxiety	Y	N	13.	Head Injury (Concussion)	Y	N
2.	Arthritis; Type _____	Y	N	14.	Heart Disease	Y	N
3.	Asthma; Type _____	Y	N	15.	High Cholesterol	Y	N
4.	Cancer; Type _____	Y	N	16.	High Blood Pressure	Y	N
5.	Cardiac Arrest	Y	N	17.	Kidney Disease	Y	N
6.	Carotid Artery Occlusion	Y	N	18.	Mental Disease	Y	N
7.	Chronic Pain	Y	N	19.	Rheumatoid Arthritis	Y	N
8.	Chronic Lung Disease	Y	N	20.	Thyroid Condition	Y	N
9.	Congestive Heart Failure	Y	N	21.	Multiple Sclerosis	Y	N
10.	Diabetes Mellitus Type 1	Y	N	22.	Dementia	Y	N
11.	Diabetes Mellitus Type 2	Y	N	23.	Eczema	Y	N
12.	Depressive Disorder	Y	N	24.	Other (horomone) endocrine disorder	Y	N

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Social History

Do you currently smoke? Y N If yes, how many cigarettes or packs per day? _____

Have you ever smoked? Y N If yes, please specify when and how long _____

Do you drink alcohol? Y N If yes, please specify how many times per month _____

Have you ever used or do you currently use recreational drugs? Y N Type _____

Family Health History

Do any of your immediate family have any of the following conditions? If yes, please specify their relationship to you (i.e. mother, brother, maternal grandmother, etc.)

1. Amblyopia (lazy eye) Y N Relationship: _____
2. Blindness Y N Relationship: _____
3. Cataract Y N Relationship: _____
4. Macular Degeneration Y N Relationship: _____
5. Glaucoma Y N Relationship: _____
6. Retinal Disorder Y N Relationship: _____
7. Strabismus (eye turn) Y N Relationship: _____
8. Arthritis Y N Relationship: _____
9. Cancer Y N Relationship: _____
10. Diabetes Y N Relationship: _____
11. Endocrine Disease Y N Relationship: _____
12. High Cholesterol Y N Relationship: _____
13. Cardiovascular Disease Y N Relationship: _____
14. High Blood Pressure Y N Relationship: _____
15. Stroke Y N Relationship: _____
16. Rheumatoid Arthritis Y N Relationship: _____
17. Thyroid Condition Y N Relationship: _____
18. Keratoconus Y N Relationship: _____

Current Medications and Dosage:

Medication	**Dosage**	**Times Taken Per Day**

Pharmacy _____

Personal Interests

The Doctors at Snowy Range Vision Center are interested in your visual needs, please list any hobbies you enjoy:

_____

Thank you!