

Health History

Name: _____ Date: _____

Were you referred to us? No Yes: by: _____

Do you have any special concerns regarding your eyes or vision? No Yes

Specify: _____

Ocular History

Do you currently wear glasses? No Yes: how often? _____

Do you currently wear contacts? No Yes: how often? _____

Do you have any of the following conditions or diagnosis?

- | | | | |
|--------------------------------|--|---------------------------|--|
| 1. Macular degeneration | <input type="checkbox"/> No <input type="checkbox"/> Yes | 9. Retinopathy | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 2. Blindness | <input type="checkbox"/> No <input type="checkbox"/> Yes | 10. Vitreous flashes | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 3. Cataracts (or had removed) | <input type="checkbox"/> No <input type="checkbox"/> Yes | 11. Vitreous floaters | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 4. Glaucoma | <input type="checkbox"/> No <input type="checkbox"/> Yes | 12. Strabismus (eye turn) | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 5. Hypermetropia (far-sighted) | <input type="checkbox"/> No <input type="checkbox"/> Yes | 13. Amblyopia (lazy eye) | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 6. Myopia (near-sighted) | <input type="checkbox"/> No <input type="checkbox"/> Yes | 14. Retinal defect | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 7. Presbyopia | <input type="checkbox"/> No <input type="checkbox"/> Yes | 15. Keratoconus | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 8. Dry eye | <input type="checkbox"/> No <input type="checkbox"/> Yes | 16. Double Vision | <input type="checkbox"/> No <input type="checkbox"/> Yes |

Other eye injury or disease; please specify: _____

Health History

Do you have any allergies? No Yes: _____

Are you allergic to any medications? No Yes: _____

Do you have any of the following conditions or diagnosis?

1. Anxiety/depression No Yes
2. Dementia No Yes
3. Arthritis No Yes
4. Asthma No Yes
5. High cholesterol No Yes
6. High blood pressure No Yes
7. Kidney disease No Yes: specify: _____
8. Autoimmune disorder No Yes: specify: _____
9. Cardiovascular disease No Yes: specify: _____
10. Thyroid disorder No Yes: specify: _____
11. Cancer No Yes: specify: _____
12. Mental disorder No Yes: specify: _____
13. Head injury (concussion) No Yes: specify: _____ when: _____
14. Diabetes No Yes: type: _____ since: _____
15. Other No Yes: specify: _____

What pharmacy do you use? _____

What are your current medications and dosages?

Medication	Dosage	Times Taken Per Day

Social History

Have you ever smoked? No Yes: when/how long _____

Do you currently smoke? No Yes: how many cigarettes or packs per day _____

Do you drink alcohol? No Yes: how many times per week _____

Have you ever used or do you currently use recreational drugs? No Yes: type _____

Family Health History

Do any of your immediate family (parents, grandparents, siblings) have any of the following conditions? If so, please specify their relationship to you.

1. Amblyopia (lazy eye) No Yes: Relationship: _____
2. Blindness No Yes: Relationship: _____
3. Cataract No Yes: Relationship: _____
4. Macular Degeneration No Yes: Relationship: _____
5. Glaucoma No Yes: Relationship: _____
6. Retinal Disorder No Yes: Relationship: _____
7. Strabismus (eye turn) No Yes: Relationship: _____
8. Arthritis No Yes: Relationship: _____
9. Cancer No Yes: Type: _____ Relationship: _____
10. Diabetes No Yes: Type: _____ Relationship: _____
11. Endocrine Disease No Yes: Type: _____ Relationship: _____
12. High Cholesterol No Yes: Relationship: _____
13. Cardiovascular Disease No Yes: Type: _____ Relationship: _____
14. High Blood Pressure No Yes: Relationship: _____
15. Stroke No Yes: Relationship: _____
16. Rheumatoid Arthritis No Yes: Relationship: _____
17. Thyroid Condition No Yes: Type: _____ Relationship: _____
18. Keratoconus No Yes: Relationship: _____

Personal Interests

What is your occupation? _____

What hobbies do you enjoy? _____

How many hours per day do you spend on the computer? _____