HEALTH HISTORY FORM

Date: _____ Name: _____ Date of Birth: _____

MEDICAL HISTORY:

Have you ever been diagnosed with	(Circle one)		Year Diagnosed	**DOCTOR/ TECHNICIAN USE ONLY**
Cholesterol	YES	NO		
Diabetes	YES	NO		
High blood pressure	YES	NO		
Heart disease	YES	NO		
Stroke	YES	NO		
Thyroid – Type_____	YES	NO		
Cancer – Type _____	YES	NO		
Seizures	YES	NO		
HIV	YES	NO		
Hepatitis	YES	NO		
Lung disease	YES	NO		
Other	YES	NO		

List Medications: (Include Aspirin And Vitamins) _____

List All Allergies To Medications And Food: _____

EYE HISTORY:

Have You Ever Been Diagnosed Or Treated For Any Of The Following?:

	(Circle One)		Which Eye /Date Of Treatment	**DOCTOR/ TECHNICIAN USE ONLY**
Cataracts	YES	NO		
Glaucoma	YES	NO		
Retina	YES	NO		
Cornea	YES	NO		
Amblyopia (Lazy Eye)	YES	NO		
Strabismus surgery	YES	NO		
Uveitis	YES	NO		
Trauma	YES	NO		
Other	YES	NO		

SURGICAL HISTORY:	(Circle One)		DATE OF SURGERY	**DOCTOR/TECHNICIAN USE ONLY**
Heart	YES	NO		
Vascular	YES	NO		
Breast	YES	NO		
Hysterectomy	YES	NO		
Gallbladder	YES	NO		
Appendix	YES	NO		
Hernia	YES	NO		
Prostate	YES	NO		
Tonsils	YES	NO		
Other	YES	NO		

FAMILY HISTORY OF HEALTH AND/OR EYE DISEASE: **DOCTOR/TECHNICIAN USE ONLY**

SOCIAL HISTORY: Do You Use Or Have You Ever Used:

Tobacco: Circle one Current Amt Per Day: _____ Past Year Stopped: _____ Never

Alcohol YES NO If Yes, How much: _____ per Day Week Year (circle)

Occupation: _____

DOCTOR/TECHNICIAN USE ONLY:

REVIEW OF SYSTEMS:

1.	Constitutional	+	-	6.	Genitourinary	+	-	11.	Heme/Lymph	+	-
2.	Ear/Nose/Throat	+	-	7.	Integumentary	+	-	12.	Musculoskeletal	+	-
3.	Cardiovascular	+	-	8.	Neurological	+	-	13.	Allergic/Immune	+	-
4.	Respiratory	+	-	9.	Psychiatric	+	-				
5.	Gastrointestinal	+	-	10.	endocrine	+	-				

ROS POSITIVE: _____