

HEALTH HISTORY

Yes No

- Asthma _____
- Kidney Disease _____
- Tuberculosis _____
- Diabetes _____
- Migraines _____
- Psychiatric Disorder _____
- Nervous Disorder _____
- Heart Disease _____
- Ulcer _____
- High Blood Pressure _____
- Do you smoke? _____
- Do you drink? _____
- Taken any illegal substances within the last 12 months? _____

Yes No

- Head or Spinal injuries _____
- Seizures, Convulsions, or Fainting _____
- Extensive Confinement by Illness or Injury _____
- Temporal Arteritis _____
- Carotid Artery Disease _____
- Stroke _____
- HIV _____
- Liver Disease _____
- Rheumatoid Arthritis _____
- Cancer _____
- Sickle Cell Anemia _____
- Other Diagnosed Health Problems _____

Please list all Medications you are currently taking:

Please list all Medications you are allergic to:

YOUR OCULAR HISTORY

Yes No

- Cataracts
- Glaucoma
- Corneal Disease
- Retinal Disease

Yes No

- Cataract Surgery
- Glaucoma Surgery
- Corneal Surgery
- Retinal Surgery

Yes No

- Crossed eyes / Lazy eye
- Iritis / Uveitis
- Eye Muscle Surgery
- Other: _____

FAMILY HISTORY

Yes No

- Cataracts
- Glaucoma
- Corneal Disease

Yes No

- Macular Degeneration
- Retinitis Pigmentosa
- Diabetes

Yes No

- Heart Disease
- Stroke
- Retinal Detachment
- Other: _____

SURGICAL HISTORY (please include date & type)

Name: _____ Date: _____

Tech initial & date _____