***Health & History***

Reason for Today's Exam: _____

Previous Eye Doctor: _____

How did you hear about us? □ Friend □Family □Colleague **Their name**:_____

**Health History**

□ Anxiety
□ Arthritis
□ Asthma
□ Atrial Fibrillation
□ Irreg. Heartbeat
□ Bone Marrow Trspl
□ BPH
□ Breast Cancer
□ Colon Cancer
□ Cor. Artery Dis
□ Depression
□ Diabetes
□ End Stg. Renal Dis.
□ GERD
□ Pregnant/Nursing
□ Hearing Loss
□ Hepatitis
□ Hypertension
□ HIV/AIDS
□ Cholesterol
□ Hyperthyroid
□ Leukemia
□ Cancer
□ Lymphoma
□ Prostate Cancer
□ Radiation
□ Seizures
□ Stroke
□ Hypothyroid

**Ocular History**

□ Cataracts
□ Contact Lenses
□ Glasses
□ Diabetic Retinopathy
□ Dry Eyes
□ Glaucoma
□ Macular Deg
□ Ocular Migraine
□ Retinal Tear
□ Floaters
□ Lazy Eye/Strab

**Social History**

Current Smoker?
□ **Yes** □ **No**

Former Smoker?
□ **Yes** □ **No**

Recreational Drug Use?
□ **Yes** □ **No**

Alcohol Use?
□ **Yes** □ **No**

**Any Previous Surgeries? (Please list year)**

_____

**Any Eye Surgeries? (Please list year)**

_____

**Family History (List any parents or siblings diagnosed with the following):**

**Hypertension:**

**Diabetes:**

**Cholesterol:**

**Cancer:**

**Glaucoma:**

**Macular Degeneration:**

**Lazy Eye:**

**Do you use any Eye Drops?** □ Yes □ No If Yes, Please List:

_____

**Medications** List all current prescription & over the counter medications:

_____

**Drug Allergies:**

_____