Health & Ocular History

Name: ______________________________ Date of Birth: ____________________

	YES	NO	Which Kind (if known):
Currently Wear Glasses?			
Currently Wear Contacts?			
Previous Eye or Eyelid Surgeries? LASIK, PRK, Cataract, Corrective & Cosmetic Surgeries:			

Health/Eye History, current or past:	YES	What/When:	**Health/Eye History, current or past:**	YES	What/When:
Cataract			**Pregnancy/Breastfeeding**		
Glaucoma			**Ears/Mouth/Nose/Throat/Sinus Issues**		
Detached Retina			**Sleep Disorders**		
Diabetic Retinopathy			**High Blood Pressure**		
Macular Degeneration			**Irregular Heartbeat**		
Strabismus (Crossed Eye)			**Cardiovascular Disease**		
Amblyopia (Lazy Eye)			**Asthma/Emphysema/Lung Disease**		
Trauma/Injury			**Diabetes/Thyroid Problems**		
Low Vision/Blindness			**Stomach/Intestinal Problems**		
Other Ocular Disease			**Kidney/Urinary/Genital Disease**		
Headaches			**Mental Illness/Depression/Anxiety**		
Joint/Muscle Pain			**Dizziness/Vertigo/Fainting**		
Skin Issues			**Blood Disorders/Prolonged Bleeding**		
AutoImmune Disease			**HIV/AIDS**		
Stroke/Neurological Disease			**Smoker/Recreational Drug Use**		
Seasonal Allergies			**Fever/Weight Loss**		
Unusual Reactions to Anesthetics			**Other Health Issues**		
High Cholesterol			**Other Health Issues**		

Current Medications *(List all Current Medications, Eye Drops, Supplements, or any "over-the-counter" medications):*

______________________________ ______________________________

______________________________ ______________________________

Allergies *(List all medical or other allergies here):*

______________________________ ______________________________

Family History *(List any current or past Eye & Medical conditions of your Immediate Family; Parents, Siblings, Children):*

______________________________ ______________________________

Name & Office of Primary Care Practitioner*:* Date Last Seen by Primary Care Practitioner*:*

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______________________________ ______________________________

SIGNED **DATED**