Patient Health History Form

Name:_____ Today's Date:_____
Address:_____ Home Phone:_____
_____Work Phone :_____
E-Mail: _____ Cell Phone_____
Age: __ Birth Date: _____ SSN:_____ Occupation:_____
Last Eye Exam:_____ Name of Medical Doctor:_____ Dr's Phone:_____

Medical History

Do you have any allergies to any medications? Y N If so, explain: _____

List any medications you take (including oral contraceptives, aspirin, over-the-counter and home remedies):
_____
_____
_____

List all major injuries, surgeries, and/or hospitalizations:
_____
_____

Check any of the following that you have had:
□ Crossed eyes □ Lazy eye □ Drooping eyelid □ Prominent eyes □ Glaucoma □ Retinal disease □ Cataracts □ Eye infections □ Eye injury □ Other: _____

Are you pregnant and/or nursing? □ Yes □ No

Do you wear glasses? □ Yes □ No If yes, how old is your present pair of lenses?_____
Do you wear contact lenses? □ Yes □ No If yes, how old is your present pair of lenses?_____
Type of contact lenses: □ RGP □ Soft □ Extended Wear □ Other Are they comfortable? □ Yes □ No

Family History

Please note any family members (parents, grandparents, siblings, living or deceased) for the following conditions if applicable:

Disease / Condition	Yes	No	Relationship to you
Blindness	□	□	_____
Cataracts	□	□	_____
Crossed Eyes	□	□	_____
Glaucoma	□	□	_____
Macular Degeneration	□	□	_____
Retinal Detachment / Disease	□	□	_____
Arthritis	□	□	_____
Cancer	□	□	_____
Diabetes	□	□	_____
Heart Disease	□	□	_____
High Blood Pressure	□	□	_____
Kidney Disease	□	□	_____
Lupus	□	□	_____
Thyroid Disease	□	□	_____
Other:_____			_____

**** Please Turn This Form Over And Complete Side Two ****