PERSONAL HEALTH HISTORY

PLEASE INDICATE ANY MEDICAL CONDITIONS IN THE FOLLOWING AREAS

CONSTITUTION
(e.g. Developmental Disability, Cancer, Chills, Fatigue, Fever, Insomnia, Weight Loss/Gain, Other)_____
☐ NONE

EARS, NOSE AND THROAT
(e.g. Hearing Loss, Sinusitis, Dry Mouth, Laryngitis, Oral Herpes, Other)_____
☐ NONE

NEUROLOGICAL
(e.g. MS, Epilepsy, Cerebral Palsy, Tumor, Stroke, Migraines, Seizures, Autism, Other)_____
☐ NONE

PSYCHIATRIC
(e.g. Depression, ADHD, Anxiety/ Panic Attacks, Nervousness, Bipolar, Dementia, Other)_____
☐ NONE

CARDIOVASCULAR
(e.g. High Blood Pressure, Stroke, Heart Disease, Vascular Disease, Congestive Heart Failure, Other)_____
☐ NONE

RESPIRATORY
(e.g. Asthma, Bronchitis, Emphysema, COPD, Sleep Apnea, TB, Other)_____
☐ NONE

GASTROINTESTINAL
(e.g. Crohn's, Colitis, Ulcer, Acid Reflux, GERD, Celiac Disease, Diarrhea, Hernia, Other)_____
☐ NONE

GENITOURINARY
(e.g. Prostate, Kidney, STD, Pregnant, Herpes, Chlamydia, Uterine, Nursing, Ovaries, Testicles, Bladder, Other)_____
☐ NONE

MUSCULOSKELETAL
(e.g. Arthritis, Fibromyalgia, Osteoporosis, Gout, Neck Pain, Back Pain, Other)_____
☐ NONE

INTEGUMENTARY
(e.g. Eczema, Rosacea, Psoriasis, Herpes Simplex, Shingles, Dermatitis, Skin Rash, Other)_____
☐ NONE

ENDOCRINE
(e.g. Diabetes, Hypothyroidism, Graves Disease, Goiter, Hypoglycemia, Hormonal Dysfunction, Other)_____
☐ NONE

HEMATALOGIC/LYMPHATIC
(e.g. Anemic, Large Volume Blood Loss, High Cholesterol, Lymphoma, Other)_____
☐ NONE

ALLERGIC/IMMUNOLOGIC
(e.g. Allergies, Rheumatoid Arthritis, Lupus, Sjogren's, Disease, HIV, Immune Disorder, Other)_____
☐ NONE

SOCIAL HABITS:
TOBACCO: ☐ NEVER A SMOKER / ☐ QUIT SMOKING AT AGE____ / ☐ SMOKER: ____PACKS PER DAY
ALCOHOL: ☐ NON-DRINKER / ☐ <1U/DAY / ☐ 1-2U/DAY / ☐ 3-6U/DAY / ☐ 7-9U/DAY / ☐ >9U/DAY / ☐ DRY ALCOHOLIC
OTHER: ☐ NO DRUG USE / ☐ MARIJUANA / ☐ OTHER: _____

OTHER
(e.g. Head Injury, Accidents, Other)_____
☐ NONE

OCULAR HEALTH HISTORY

DO YOU HAVE ANY PROBLEMS IN THESE AREAS?

			How long?
GLAUCOMA	Y	N	_____
CATARACTS	Y	N	_____
MACULAR DEGENERATION	Y	N	_____
EYE INJURY	Y	N	_____
RETINAL DISEASE	Y	N	_____
OTHER EYE DISEASE	Y	N	_____
BLINDNESS	Y	N	_____
STRABISMUS (crossed eyes)	Y	N	_____
AMBLYOPIA (lazy eye)	Y	N	_____
DIABETIC RETINOPATHY	Y	N	_____
DRY EYE	Y	N	_____
OTHER EYE PROBLEM	Y	N	_____

Please check all that apply:

GLASSES: ☐ NONE / ☐ FULL TIME / ☐ PART-TIME
SAFETY GLASSES _____
PRESCRIPTION SUNGLASSES _____
NON-PRESCRIPTION SUNGLASSES _____
COMPUTER GLASSES _____
GLASSES/READERS (over the counter) _____
GLASSES/READING (prescription) _____
CONTACT LENSES/DAILY WEAR _____
CONTACT LENSES/EXTENDED WEAR _____
CONTACT LENSES/MONOVISION _____
CONTACT LENSES/MULTIFOCAL _____

SURGICAL HISTORY

PROCEDURE NAME/TYPE	NONE ☐	Date of Procedure
_____		_____
_____		_____
_____		_____