



HEALTH HISTORY

PATIENT NAME: _____ **DATE** _____

- Yes/No
- Lung Disease - Type: _____
 - Kidney Disease: _____
 - Arthritis: _____
 - Diabetes _____ # of Yrs. _____
 - Neurological Disease: _____
 - Migraines: _____
 - Psychiatric Disorder _____
 - Prostate Disorder _____
 - Have you ever taken medicine for this disorder?
Type: _____
 - Nervous Disorder _____
 - Heart Disease _____
 - Gastrointestinal Disease - Type: _____
 - High Blood Pressure _____ # of Yrs. _____
 - Scarring/Keloids _____
 - Are you allergic to Latex, Rubber (Balloons)? _____

Please List All Medications You Are Currently Taking:

- Yes/No
- Head or Spinal Injuries _____
 - Seizures, Convulsions, Fainting _____
 - Temporal Arteritis _____
 - Carotid Artery Disease _____
 - (Women) Are you pregnant or nursing? _____
 - Stroke _____
 - HIV/AIDS _____ # of Yrs. _____
 - Extensive Confinement from Illness or Injury _____
 - Permanent Defect from Illness, Disease or Injury _____
 - Suffering from any other Disease _____
 - Do you smoke?# Packs per Day Week Month
 - Do you drink? _____ #per Day Week Month
 - Are you allergic to Bananas, Pears, Avocado, Chestnuts?
 - Do you live alone? _____

Your Medical Doctor _____

Please List All Medication Allergies:

Have You Been Diagnosed With or Treated for Any of the Following:

- Yes/No
- Cataracts
 - Crosses Eyes
 - Retinal Disease _____
 - Injury _____

Cataract Surgery Date: _____ Right Eye
 Do you have a lense implant? Yes No
 Other Eye Surgery/Date: _____ Right Eye
 Type of Eye Injury (if any)

- Yes/No
- Corneal Disease
 - Glaucoma
 - iritis
 - Other Eye Disorders: _____

Cataract Surgery Date: _____ Left Eye

Cataract Surgery Date: _____ Left Eye

Has any family member (mother, father,sisters or brothers) Been Treated for the Following:

- Yes/No
- Glaucoma _____
 - Cataracts _____
 - Macular Degeneration _____
 - Diabetic Retinopathy _____
 - Diabetes _____
 - Stroke _____

- Yes/No
- Retinal Detachment _____
 - Corneal Disease _____
 - Retinitis Pigmentosa _____
 - Other Eye Problems _____
 - Heart Disease _____
 - Other Health Conditions _____

Please List any Previous Surgeries and their Date: (Please continue on back of form)



PATIENT NAME: _____

Previous Surgeries and Dates: (Continued)

_____	_____
_____	_____
_____	_____
_____	_____

Date Reviewed & Updated	_____	Tech Signature	_____
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