Health History

Patient Name: ______________________________

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 Disease: ______________________
- ☐ ☐ Heart Disease: ______________________
- ☐ ☐ Gastrointestinal Disease:

Type: ______________________________

- ☐ ☐ High Blood Pressure: __________ # of Yrs: ______
- ☐ ☐ Scarring/Keloids: ______________________
- ☐ ☐ Are you allergic to Latex, Rubber? ______________

Date: ______________________________

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, Disease or Injury:

____

- ☐ ☐ Permanent Defect from Illness, Disease or Injury:

____

- ☐ ☐ Do you smoke? Y___N____ Packs per day__________
- ☐ ☐ 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 Medications You Are Currently Taking:

____
____
____
____

Please List All Medication Allergies:

____
____
____
____

If over age 65 please indicate if you have ever had a Pneumonia Vaccine: ☐ Yes ☐ No Date of Vaccine:______________

Have You Been Diagnosed With or Treated For Any Of The Following:

Yes/No

- ☐ ☐ Cataracts
- ☐ ☐ Crossed Eyes
- ☐ ☐ Retinal Disease: ______________________

Type of Eye Injury (if any): ______________________

Cataract Surgery Date: __________________ Right Eye

Do you have a lens implant: € Yes € No

Other Eye Surgery Date: __________________ Right Eye

Yes/No

- ☐ ☐ Corneal Disease: ______________________
- ☐ ☐ Glaucoma
- ☐ ☐ Irisitis
- ☐ ☐ Other Eye Disorders: ______________________

Cataract Surgery Date: __________________ Left Eye

Other Eye 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 Dates: (Please Continue On Back Of Form.)

____
____
____
____

Patient Name: ________________________________

Previous Surgeries and Dates: (Continued)

____ ____
____ ____
____ ____
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Date Reviewed and Updated: _____________________ **Tech Signature:** ________________________________
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