HEALTH HISTORY QUESTIONNAIRE

Name _____Date of Birth _____ Date _____

List any medications you currently take (Rx and/or over the counter): Date of **last eye exam** _____

_____

_____

Do you have any allergies to any medications or substances, including Latex? (Circle one): **YES NO**

Do you have any reactions to anesthesia? (Circle one): **YES NO**

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):

_____

List any surgeries you have had (cataract, appendectomy, etc.) and the year(s) they were performed (last 10 years):

_____

Do you currently have any problems in the following areas? **If YES,** please provide additional information.

	YES	NO	Additional Information
EYES (Poor vision, eye pain, tearing, redness)			
GENERAL / CONSTITUTIONAL (Fever, heat stroke, weight loss or gain, fatigue)			
EAR / NOSE / THROAT (Hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (High BP, racing pulse, etc.)			
RESPIRATORY (Congestion, wheezing, shortness of breath, etc.)			
GASTROINTESTINAL (Stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (Painful or frequent urination, impotence, jaundice, prostate)			
FEMALES (Are you pregnant? Nursing?)			
MUSCLE, BONES, JOINTS (Joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (Pimples, warts, growths, rash, eczema, etc.)			
NEUROLOGICAL (Numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, thyroid, etc.)			
BLOOD / LYMPH (Bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES NO** Caffeine? **YES NO**

Have you ever had a blood transfusion? **YES NO** Do you use recreational drugs? **YES NO FORMERLY**

Do you drink alcohol? **YES NO If YES,** how much? _____ How often? _____

Do you use tobacco? **YES NEVER FORMERLY** How much? _____

If FORMERLY, how long? _____ When did you stop? _____

Patient Signature_____ Date _____