

HEALTH HISTORY

PATIENT NAME _____ **DATE** _____

Yes No <input type="checkbox"/> Lung Disease -Type: _____ <input type="checkbox"/> <input type="checkbox"/> Kidney Disease: _____ <input type="checkbox"/> <input type="checkbox"/> Arthritis: _____ <input type="checkbox"/> <input type="checkbox"/> Diabetes _____ #of Yrs _____ <input type="checkbox"/> <input type="checkbox"/> Neurological Disease: _____ <input type="checkbox"/> <input type="checkbox"/> Migraines _____ <input type="checkbox"/> <input type="checkbox"/> Psychiatric Disorder _____ <input type="checkbox"/> <input type="checkbox"/> Nervous Disorder _____ <input type="checkbox"/> <input type="checkbox"/> Heart Disease _____ <input type="checkbox"/> <input type="checkbox"/> Gastrointestinal Disease – Type: _____ <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure: _____ #of Yrs _____ <input type="checkbox"/> <input type="checkbox"/> Scarring / Keloids _____ <input type="checkbox"/> <input type="checkbox"/> Are You Allergic to Latex, Rubber (Balloons)? _____	Yes No <input type="checkbox"/> <input type="checkbox"/> Head or Spinal Injuries _____ <input type="checkbox"/> <input type="checkbox"/> Seizures, Convulsions, Fainting _____ <input type="checkbox"/> <input type="checkbox"/> Temporal Arteritis _____ <input type="checkbox"/> <input type="checkbox"/> Carotid Artery Disease _____ <input type="checkbox"/> <input type="checkbox"/> (Women) Are you pregnant or nursing? _____ <input type="checkbox"/> <input type="checkbox"/> Stroke _____ <input type="checkbox"/> <input type="checkbox"/> HIV/AIDS _____ # of Yrs _____ <input type="checkbox"/> <input type="checkbox"/> Extensive Confinement from Illness or Injury _____ <input type="checkbox"/> <input type="checkbox"/> Permanent Defect from Illness, Disease or Injury _____ <input type="checkbox"/> <input type="checkbox"/> Suffering from any other Disease _____ <input type="checkbox"/> <input type="checkbox"/> Do You Smoke? # _____ Packs per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> <input type="checkbox"/> Do You Drink? # _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> <input type="checkbox"/> Are You Allergic to Bananas, Pears Avocado, Chestnuts? _____ <input type="checkbox"/> <input type="checkbox"/> Do You Live Alone? _____
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YOUR MEDICAL DOCTOR _____

Please List All Medications You Are Currently Taking:

Please List All Medication Allergies:

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

Yes No Yes No <input type="checkbox"/> <input type="checkbox"/> Cataracts _____ <input type="checkbox"/> <input type="checkbox"/> Crosses Eyes _____ <input type="checkbox"/> <input type="checkbox"/> Retinal Disease _____ <input type="checkbox"/> <input type="checkbox"/> Injury _____	<input type="checkbox"/> <input type="checkbox"/> Corneal Disease _____ <input type="checkbox"/> <input type="checkbox"/> Glaucoma _____ <input type="checkbox"/> <input type="checkbox"/> Iritis _____ <input type="checkbox"/> <input type="checkbox"/> Other Eye Disorders: _____
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Cataract Surgery Date: _____ Right Eye _____ Left Eye _____
Do You Have a Lens Implant? Yes No

Other Eye Surgery/Date: Right Eye _____ Left Eye _____
Type of Eye Injury (if any): _____

Has any Family Member (Mother, Father, Sisters or Brothers) Been Treated for the Following?

Yes No Yes No <input type="checkbox"/> <input type="checkbox"/> Glaucoma _____ <input type="checkbox"/> <input type="checkbox"/> Cataracts _____ <input type="checkbox"/> <input type="checkbox"/> Macular Degeneration _____ <input type="checkbox"/> <input type="checkbox"/> Diabetic Retinopathy _____ <input type="checkbox"/> <input type="checkbox"/> Diabetes _____ <input type="checkbox"/> <input type="checkbox"/> Stroke _____	<input type="checkbox"/> <input type="checkbox"/> Retinal Detachment _____ <input type="checkbox"/> <input type="checkbox"/> Corneal Disease _____ <input type="checkbox"/> <input type="checkbox"/> Retinitis Pigmentosa _____ <input type="checkbox"/> <input type="checkbox"/> Other Eye Problems _____ <input type="checkbox"/> <input type="checkbox"/> Heart Disease _____ <input type="checkbox"/> <input type="checkbox"/> Other Health Conditions _____
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Please List any Previous Surgeries and their Date:

Tech. Signature: _____