Chart:____________ **Health History Questionnair[e]** **DOB:**____________

Date____________ **Intls**_____

Name:________________________________ **Female or Male** **Date**____________ **Intls**_____

Yes	No	Medical Information		Yes	NO	Medical Information
		Asthma/Bronchitis/Emphysema_______________				Head or spinal injuries ____________________
		Kidney Disease				Seizures, convulsions, or fainting
		Tuberculosis				Extensive confinement by illness or injury
		Diabetes IDDM/Type II year diagnosed_____				Elevated Cholesterol
		Insulin				Carotid Artery Disease
		Migraines				Permanent defects from illness, disease or injury
		Psychiatric Disorder				(Women) are you pregnant?
		Any nervous disorder				High Blood Pressure
		Heart Disease				Stroke
		Ulcer/ GERD				HIV/Hepatitis
		Allergic to any Medications				Other diagnosed health problems

Current Medications ****PRINT****

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SURGICAL HISTORY (Please include date & type)

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YOUR OCULAR HISTORY (Have you been diagnosed with any of the following in the past?)

Yes	No	History		Yes	No	History
		Cataracts______________________				Cornea Disease______________________
		Retina Disease				Glaucoma
		Crossed eyes				Injury
		Iritis				Other eye disorders

Eye Surgeries	**Yes**	**No**	**Right**	**Left**
Cataract Surgery				
Retina Surgery				

FAMILY HISTORY (Has anyone in your family {blood relative} had any of the following in the past?)

Yes	No	Family History	Family Member	Yes	No	Family History	Family Member
		Glaucoma				Diabetes IDDM/Type II	
		Cataracts				Heart	
		Cornea Disease				Diabetic Retinopathy	
		Macular Degeneration				Retinal Detachment	
		Retinitis Pigmentosa				Stroke	
		Other Eye Problems				Other health problems	

SOCIAL HISTORY

Do you drink alcohol?	Occasionally	Frequently	Never
Do you use Drugs?	Occasionally	Frequently	Never
Do you use Tobacco	Occasionally	Frequently	Never

(for office only-continued on) (form E)

Doctor's Signature or Initials______________________________