HEALTH HISTORY

PATIENT NAME____**DATE**________________

Yes No

☐ ☐ Lung Disease -Type:_____________
☐ ☐ Kidney Disease:________________
☐ ☐ Arthritis:_______________________
☐ ☐ Diabetes______________________ #of Yrs____
☐ ☐ Neurological Disease:_____________
☐ ☐ Migraines _________________________________
☐ ☐ Psychiatric Disorder_______________________
☐ ☐ Nervous Disorder __________________________
☐ ☐ Heart Disease ______________________________
☐ ☐ Gastrointestinal Disease – Type: _____________
☐ ☐ High Blood Pressure:____________ #of Yrs____
☐ ☐ Scarring / Keloids
☐ ☐ Are You Allergic to Latex, Rubber (Balloons)?

YOUR MEDICAL DOCTOR______________________

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?

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

☐ ☐ Cataracts
☐ ☐ Crosses Eyes
☐ ☐ Retinal Disease __________________________
☐ ☐ Injury ____________________________________
☐ ☐ Corneal Disease
☐ ☐ Glaucoma
☐ ☐ Iritis
☐ ☐ Other Eye Disorders: ______________________________

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

☐ ☐ Glaucoma ______________________________
☐ ☐ Cataracts _______________________________
☐ ☐ Macular Degeneration _____________________
☐ ☐ Diabetic Retinopathy ______________________
☐ ☐ Diabetes _________________________________
☐ ☐ Stroke ___________________________________
☐ ☐ Retinal Detachment _____________________________
☐ ☐ Corneal Disease _________________________________
☐ ☐ Retinitis Pigmentosa ______________________________
☐ ☐ Other Eye Problems _______________________________
☐ ☐ Heart Disease _____________________________________
☐ ☐ Other Health Conditions ____________________________

Please List any Previous Surgeries and their Date:

____ ____
____ ____

Tech. Signature: ______________________________________