PATIENT HISTORY

Print Name: ____ Date: ________________

HAVE YOU HAD OR DO YOU HAVE:

1.	High Blood Pressure	YES	NO
2.	Heart Attack	YES	NO
3.	Chest Pain (angina)	YES	NO
4.	Skipped Heart Beat	YES	NO
5.	Fainting or Black Outs	YES	NO
6.	Asthma	YES	NO
7.	Emphysema, Bronchitis	YES	NO
8.	Shortness of Breath	YES	NO
9.	Seizures or Stroke	YES	NO
10.	Paralysis or Numbness	YES	NO
11.	Hepatitis or Jaundice	YES	NO
12.	HIV/AIDS	YES	NO
13.	Kidney Disease	YES	NO
14.	Diabetes	YES	NO
15.	Anemia	YES	NO
16.	Muscle Disease	YES	NO
17.	Thyroid Disease	YES	NO
18.	Arthritis	YES	NO
19.	Brain Tumor	YES	NO
20.	Psychiatric Disorders	YES	NO
21.	Mental Disorders	YES	NO
22.	Migraine Headaches	YES	NO
23.	Cataracts	YES	NO
24.	Double Vision	YES	NO
25.	Lens Implants or Contacts	YES	NO
26.	Glaucoma	YES	NO
27.	Retinal Disease	YES	NO

DO YOU:

1.	Smoke	YES	NO
2.	Drink Alcohol	YES	NO
3.	Live Alone	YES	NO

DOES ANYONE IN YOUR FAMILY HAVE:

1.	Cataracts	YES	NO
2.	Glaucoma	YES	NO
3.	Retinal Disease	YES	NO
4.	Heart Disease	YES	NO
5.	Diabetes	YES	NO

LIST PREVIOUS SURGERIES:

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LIST MEDICATIONS YOUR ARE TAKING:

Prescription and over-the-counter

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LIST DRUG ALLERGIES:

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PATIENT SIGNATURE:

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