



**CATARACT & LASER
EYE SURGEONS
HEALTH HISTORY FORM**

Name of Patient: _____ Phone#: _____ Date of Birth: _____
 (last) (first) (MI)

Address: _____ City: _____ State: _____ Zip: _____

Who referred you to this office? _____ Physician's Name: _____
 Email _____ Person filling out this form: SELF or _____

Today's Eye Problem: _____

When did the problem start? _____ Is it still present? Yes or No If no, how long did it last? _____

HEALTH HISTORY (Check those that apply)

<u>Eye Diseases</u>	<u>Impairments</u>	<u>Chronic or Recurring Illness</u>	<u>Allergies</u>	
<input type="checkbox"/> Cataract	<input type="checkbox"/> Difficulty reading a book	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Medication*	<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Difficulty reading at a distance	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Seasonal	<input type="checkbox"/> Hearing Aid
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Double vision	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other	<input type="checkbox"/> Contact Lenses
<input type="checkbox"/> Diabetic Retinopathy	<input type="checkbox"/> Severe eye pain	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/> Other:
<input type="checkbox"/> Retinal Diseases	<input type="checkbox"/> Glare from bright lights	<input type="checkbox"/> Asthma	<input type="checkbox"/>	_____
<input type="checkbox"/> Cornea Disease	<input type="checkbox"/> Other	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	_____
<input type="checkbox"/> Dry Eye	<input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/> Musculoskeletal Disorders	<input type="checkbox"/>	
		<input type="checkbox"/> Other (Specify):	<input type="checkbox"/>	

Explain: _____

* If yes, which medications?

Family History (please circle all that apply)

Glaucoma, Retinal problems, "Lazy Eye", Heart Disease, Diabetes, High Blood Pressure, Migraine, Arthritis, Stroke

Medication List (Please list all Prescription and Over-the-Counter medication)
