Shoreline Vision

HEALTH HISTORY FORM

NAME: _____ **DOB:** _____

EYE HISTORY ***Do you currently wear: Glasses Y/N, Contacts Y/N***

		Surgeries/Procedures
Refractive	Y/N	_____
Cataract	Y/N	_____
Glaucoma	Y/N	_____
Eye lids	Y/N	_____
Cornea	Y/N	_____
Retina	Y/N	_____
Muscle	Y/N	_____
Injuries	Y/N	_____

EYE MEDICATIONS ___***None***

(include over the counter medicines)

_____

_____

_____

MEDICAL HISTORY		**Condition/Surgeries**
Heart	Y/N	_____
High Blood Pressure	Y/N	_____
High Cholesterol	Y/N	_____
Skin	Y/N	_____
Stomach	Y/N	_____
Kidney/Urinary	Y/N	_____
Headaches	Y/N	_____
Unusual Bleeding	Y/N	_____
Diabetes *year* _____	Y/N	_____
Thyroid	Y/N	_____
Arthritis	Y/N	_____
Back	Y/N	_____
Cancer *year*_____	Y/N	_____
Stroke	Y/N	_____
Depression	Y/N	_____
Nervousness/Tremor	Y/N	_____
Significant Weight Loss	Y/N	_____
Breathing	Y/N	_____
Pregnant/Nursing	Y/N	
Other:		_____
Sinus Problems:	Y/N	_____

FAMILY HISTORY	**RELATIVE**
Cataract	Y/N _____
Glaucoma	Y/N _____
Retinal Detach	Y/N _____
Macular Degen	Y/N _____
Blindness	Y/N _____
Diabetes	Y/N _____
Heart Disease	Y/N _____
Adopted/Unknown	Y/N

SOCIAL HISTORY

Smoke Y/N Amt _____

Prev smoker Y/N Quit _____

Alcohol Y/N

Caffeine Y/N

Drug Allergies (reaction) _____

_____ _____

_____ _____

MEDICATIONS (include dosage/mg.) ***include over the counter medications, vitamins, supplements, etc.***

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____