Patient Health History Form

Please answer the following questions:

1. Do you have diabetes? _____ If yes, when were you diagnosed? _____Type 1 or Type 2? _____

2. Do you have high blood pressure? _____ If yes, when were you diagnosed? _____

3. Please list any medical issues involving your eyes:

_____

4. Please list any other health issues you have had:

_____

_____

5. Please list any surgeries you have had, including eye surgeries. Please include the approximate date of surgery:

_____

_____

6. Please list all medications you are currently taking, including medications for your eyes, vitamins, insulin, and aspirin:

_____

_____

7. Have you had your flu shot? _____

8. Have you had your pneumococcal vaccine? _____

9. Please list any allergies:

_____

10. Do you have a family history of Age-Related Macular Degeneration? _____

If yes, who in your family had it? _____

11. Do you have a family history of Glaucoma? _____

If yes, who in your family had it? _____

12. Do you have a family history of Retinal Detachment? _____

If yes, who in your family had it? _____

13. Do you have a family history of Diabetes? _____

If yes, who in your family had it? _____

14. Have you ever smoked? _____ If you used to smoke when did you quit? _____

Current smokers, when did you start? _____ How many packs per a day do you smoke? _____

15. Do you drink alcohol? _____ If yes, how often do you drink alcohol? _____

16. Do you abuse illegal substances? _____

17. Could you be pregnant? _____

Name: _____

Date of Birth: _____ **Date Completed: _____**