Health History

PALM BEACH EYE CENTER

PATIENT NAME_____ **DATE**_____

Yes / No
- ☐ ☐ Lung Disease-Type_____
- ☐ ☐ Kidney Disease_____
- ☐ ☐ Arthritis _____
- ☐ ☐ Diabetes Type_____# of yrs_____
- ☐ ☐ Neurological Disease_____
- ☐ ☐ Migraines_____
- ☐ ☐ Psychiatric Disorder_____
- ☐ ☐ Any Nervous Disorder_____
- ☐ ☐ Heart Disease_____
- ☐ ☐ Stroke_____
- ☐ ☐ High Blood Pressure_____# of yrs_____
- ☐ ☐ Scarring Keloids_____

Yes / No
- ☐ ☐ Head or Spinal Injuries_____
- ☐ ☐ Seizures, Convulsions, or Fainting_____
- ☐ ☐ Thyroid Disease ☐ Low Thyroid ☐ High Thyroid
- ☐ ☐ Carotid Artery Disease_____
- ☐ ☐ (Women) Are you pregnant or nursing?____
- ☐ ☐ Stomach/Intestinal Disorder-Type_____
- ☐ ☐ HIV / AIDS # of yrs_____
- ☐ ☐ High Cholesterol_____
- ☐ ☐ Permanent defect from illness/injury_____
- ☐ ☐ Any other disease_____
- ☐ ☐ Smoke? Packs___ Per Day / Week / Month
- ☐ ☐ Drink? Drinks____ Per Day / Week / Month

Please list all Medications that you are currently taking:

_____

_____

_____

Please list all Drug Medications you are Allergic to:

_____

Your Ocular History (Have you been diagnosed with any of the following in the past?)

Yes / No
- ☐ ☐ Cataracts_____
- ☐ ☐ Retinal Disease_____
- ☐ ☐ Crossed Eyes_____
- ☐ ☐ Iritis_____

Yes / No
- ☐ ☐ Corneal Disease_____
- ☐ ☐ Glaucoma_____
- ☐ ☐ Other Eye Disorder_____
- ☐ ☐ Injury-Explain_____

_____

In the past have you had:

1. Cataract Surgery ☐ Right_____ (Date of Surgery) ☐ Left_____ (Date of Surgery)
2. Other Eye Surgery ☐ Right_____ (Date of Surgery) ☐ Left_____ (Date of Surgery)

Family History (Has anyone if you family (blood relative) had any of the following?)

Please note relationship to patient: F-Father **M**-Mother **P**-Paternal **M**-Maternal **S**-Sister **B**-Brother **GF**-Grandfather **GM**-Grandmother **U**-Uncle **A**-Aunt

Yes / No
- ☐ ☐ Glaucoma_____
- ☐ ☐ Cataracts_____
- ☐ ☐ Corneal Disease_____
- ☐ ☐ Macular Degeneration____
- ☐ ☐ Retinitis Pigmentosa_____
- ☐ ☐ Diabetic Retinopathy_____

Yes / No
- ☐ ☐ Retinal Detachment_____
- ☐ ☐ Other Eye Problem_____
- ☐ ☐ Diabetes_____
- ☐ ☐ Heart Conditions_____
- ☐ ☐ Stroke_____
- ☐ ☐ Other Health Problems___

Surgical History (Please include Date and Type, use additional sheet if necessary)

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