HEALTH HISTORY FORM

YES NO HEART DISEASE

YES NO HEART ATTACK **OR** ANGINA

YES NO HIGH BLOOD PRESSURE

YES NO COPD **OR** Asthma

YES NO DIABETES NON-INSULIN **OR** INSULIN DEPENDANT

YES NO KIDNEY DISEASE

YES NO LIVER DISEASE **OR** HEPATITIS

YES NO ULCER

YES NO STROKE **OR** TIA

YES NO SEIZURES, CONVULSIONS **OR** FAINTING

YES NO ARE YOU TAKING OR HAVE YOU TAKEN SABRIL?

YES NO ARE YOU USING LATISSE?

YES NO MEASLES **OR** MUMPS **OR** CHICKEN POX?

YES NO HEAD **OR** SPINAL INJURIES

YES NO PERMANENT DEFECT FROM ILLNESS, DISEASE **OR** INJURY

YES NO MUSCLE DISEASE

YES NO TEMPORAL ARTERITIS

YES NO ARTHRITIS **OR** LIMITED MOVEMENT

YES NO CAROTID ARTERY DISEASE

YES NO PSYCHIATRIC DISORDER

YES NO ARE YOU PREGNANT (WOMEN)

YES NO HAVE YOU EVER TAKEN **OR** DO YOU TAKE FLOMAX (TAMSULOSIN), CARDURA, HYTRIN, RAPAFLO, **OR** UROXATRAL?

YES NO HIV

YES NO DO YOU SMOKE? # OF PACKS PER DAY____# PACKS PER WEEK_____
QUIT _______WHEN?_________

YES NO DO YOU DRINK? # OF DRINKS PER DAY_____# OF DRINKS PER WEEK_________

- HEIGHT ____________ WEIGHT____________
-
- GENERAL SURGICAL HISTORY:____
- PROBLEMS WITH ANESTHESIA? YES_____ NO_____ IF YES, WHAT REACTION?____

OCULAR HISTORY:

YES NO CATARACTS

YES NO RETINA DISEASE

YES NO CROSSED EYES **OR** LAZY EYE

YES NO IRITIS

YES NO CORNEA DISEASE

YES NO GLAUCOMA

YES NO EYE INJURY- IF YES, GIVE DETAIL:_________________________________

YES NO OTHER EYE DISORDERS- IF YES, GIVE DETAIL:______________________

HAVE YOU EVER HAD CATARACT SURGERY? YES_____ NO_____ IF YES, PLEASE LIST DATE(S) AND TYPE OF IMPLANT(S):

DATE: RIGHT _________________ LEFT _____________________

TYPE OF IMPLANT(S): RIGHT______________________ LEFT_____________________

HAVE YOU EVER HAD RETINAL SURGERY? YES_____ NO_____ IF YES, PLEASE LIST DATE(S) AND SURGEON:

DATE(S): RIGHT EYE___________________LEFT EYE__________________

TYPE OF PROCEDURE(S) PERFORMED:

____

ANY OTHER EYE SURGERIES? YES_____ NO_____ IF YES, GIVE DETAIL:

PATIENT
NAME:____DOB:______________________DATE:_______________________

FAMILY HISTORY: HAS ANYONE IN YOUR FAMILY (BLOOD RELAITIVES) HAD THE FOLLOWING IN THE PAST? NOTE RELATION TO THE PATIENT: F=FATHER, M=MOTHER, P=PATERNAL, M=MATERNAL, S=SISTER, B=BROTHER, GF=GRANDFATHER, GM=GRANDMOTHER, U=UNCLE, A=AUNT

YES NO GLAUCOMA ________

YES NO CATARACTS ________

YES NO CORNEA DISEASE_______

YES NO MACULAR DEGENERATION _______

YES NO ALZEIMERS **OR** DEMENTIA ________

YES NO HEART PROBLEMS ______

YES NO DIABETES **OR** DIABETIC RETINOPATHY ________

YES NO RETINAL DETACHMENT ______

YES NO STROKE ______

YES NO RETINITIS PIGMENTOSA _______

YES NO OTHER EYE DISORDERS -IF YES, PLEASE GIVE DETAIL____

YES NO OTHER GENERAL HEALTH PROBLEMS – IF YES, GIVE DETAIL ____

ALLERGIES:

____REACTION:____

____REACTION:____

____REACTION:____

____REACTION:____

MEDICATIONS AND STRENGTHS:

(Please list the strengths of your medications)

____ REASON FOR TAKING:____

____ REASON FOR TAKING:____

____ REASON FOR TAKING:____

____ REASON FOR TAKING:____

____ REASON FOR TAKING:____

____ REASON FOR TAKING:____

____ REASON FOR TAKING:____

____ REASON FOR TAKING:____

____ REASON FOR TAKING:____

____ REASON FOR TAKING:____

PRIMARY CARE PHYSICIAN:

____

PATIENT SIGNATURE: ____ DATE: ___________________________

For office use only

Stephen A. Updegraff, M.D., F.A.C.S. ___________________________ Daniel Behn O.D.

PATIENT NAME:____DOB:____________________DATE:_____________________