PT. #_____

CALIFORNIA EYE PROfessionals

Patient Health History

Name: **Date**:

GENERAL MEDICAL HISTORY *(Have you been diagnosed with any of the following in the past?)*

YES	NO		YES	NO	
☐	☐	High Blood Pressure / Hypertension _____	☐	☐	Sickle Cell Anemia _____
☐	☐	Heart Disease _____	☐	☐	Ulcer _____
☐	☐	Stroke _____	☐	☐	Thyroid _____
☐	☐	Carotid Artery Disease _____	☐	☐	Tuberculosis _____
☐	☐	Diabetes: ☐ IDDM ☐Type II # of yrs: _____	☐	☐	Temporal Arteritis _____
☐	☐	Kidney Disease _____	☐	☐	HIV _____
☐	☐	Asthma _____	☐	☐	(Women) Are you pregnant? _____
☐	☐	Migraines _____	☐	☐	Nervous (Neurologic) Disorder _____
☐	☐	Head or Spinal Injuries _____	☐	☐	Psychiatric Disorder _____
☐	☐	Seizures, Convulsions, Fainting _____	☐	☐	Extensive Confinement by Illness/ Injury: _____
☐	☐	Do you smoke? #yrs: _____ # packs/day: _____	☐	☐	Other(s): _____
☐	☐	Have you taken any illegal substances in the last 12 months? _____			
☐	☐	Do you drink alcoholic beverages? How often: _____			

SURGICAL HISTORY *(Please list all major surgeries)*

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING EYE DROPS): MEDICATIONS YOU ARE ALLERGIC TO:

OCULAR HISTORY *(Have you been diagnosed with any of the following in the past?)*

YES	NO		YES	NO		YES	NO	
☐	☐	Cataracts _____	☐	☐	Iritis _____	☐	☐	Injury: _____
☐	☐	Retina Disease _____	☐	☐	Cornea Disease _____	☐	☐	Other Eye Disorders: _____
☐	☐	Crossed Eyes _____	☐	☐	Glaucoma _____	☐	☐	Do you wear glasses or contact lenses? _____

Last Eye Exam Date: _____ Previous Eye Doctor(s): _____

Cataract Surgery Date(s): Right _____ Left _____ Do you have a Lens Implant? ☐ Yes ☐ No

Retina Surgery Date(s): Right _____ Left _____

Other Eye Surgery Date(s) & Type: _____

If YES for Eye Injury above, please explain: _____

FAMILY HISTORY *(Has any blood-related member of your family had any of the following?)*

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

YES	NO		YES	NO	
☐	☐	Glaucoma _____	☐	☐	Retinal Detachment _____
☐	☐	Cataracts _____	☐	☐	Diabetic Retinopathy _____
☐	☐	Cornea Disease _____	☐	☐	Diabetes: ☐ IDDM _____ ☐ Type II _____
☐	☐	Macular Degeneration _____	☐	☐	Heart Problems _____
☐	☐	Retinitis Pigmentosa _____	☐	☐	Stroke _____
☐	☐	Other Eye Problem(s): _____	☐	☐	Other General Medical Problem(s): _____

Patient Signature: _____ Tech: _____