HEALTH HISTORY

Name: Age: Date of Birth:

What is the reason for seeking treatment today? If having any problems, describe:

Circle all that apply: blind spots, blinking, blurring, bulging eye, bump, burning, crossed eye, crusting, dark curtain, decreased vision, difficulty driving, difficulty reading, difficulty with distance, discharge, distorted vision, double vision, droopy eyelids, dryness, eyelid, eye strain, floaters, foreign body sensation, glare, growth, halos, headaches, irritation, itching, lazy eye, light flashes, light sensitivity, migraines, pain, poor color vision, poor depth perception, poor night vision, poor side vision, protruding, pupils, redness, small eye, swelling, tearing, twitching

Where is your problem located?
When did your symptoms start?
Have your symptoms remained the same, worsened or improved?
Is there anything that changes symptoms?
Are your symptoms constant, intermittent or infrequent?
How severe are your symptoms on a level from 1-10?

Do you wear glasses?	**Y/N**	
Do you wear contacts?	**Y/N**	If so, what kind?
Have you tried contacts unsuccessfully?	**Y/N**	
Do you have any history of eye problems?	**Y/N**	If yes, describe:

Circle all that apply: allergies, blepharitis, blindness, cataracts, corneal disease, diabetic retinopathy, dry eyes, glaucoma, high eye pressure, infections, macular degeneration, macular membrane, narrow angle glaucoma, ophthalmic migraines, retinal tear, retinal detachment, strabismus, vitreous detachment, vitreous floaters, vitreous hemorrhage, other

Have you had any surgery or injuries to your eyes? **Y/N** If yes please describe:

Circle all that apply: blepharoplasty, cataract, corneal, eyelid, eye muscle, intravitreal injections, LASIK, laser, PRK, punctal plugs, retinal, RK, other

Are you taking any eye medications or drops? **Y/N** If yes, describe:

What is your main pharmacy and where is it located?

Are you allergic to any eye medications or drops? **Y/N** If yes, describe:

Who is you medical doctor? City located?

Do you have any medical problems? **Y/N** If yes describe:

Circle all that apply: AIDS, anemia, arthritis, asthma, autoimmune disease, birth defect, blood disorder, bronchitis, cancer, childhood disease, colitis, connective tissue disorder, COPD/emphysema, diabetes, heart disease, high blood pressure, high cholesterol, HIV+, irregular heartbeat, kidney disease, liver disease, migraines, neurologic disease, poor circulation, prostate problems, reflux, seizures, sickle cell, sinusitis, steroid use, stroke, TB, thyroid, ulcers, other

Have you ever been hospitalized? **Y/N** If yes, describe:

Have you had any non-ocular surgeries? **Y/N** If yes, describe:

Are you taking any medications? **Y/N** If yes, describe:

Are you allergic to any drugs or other products? **Y/N** If yes, describe:

Is there a family history of eye or medical diseases? **Y/N** If yes, describe:
Circle all that apply: blindness, cancer, cataract, diabetes, glaucoma, heart disease, hypertension, migraine, retinal detachment, strabismus, other

Age Occupation Marital Status

Do you drive?	**Y/N**	
Have you had any recent travel outside of the Continental USA?	**Y/N**	
Do you smoke?	**Y/N**	If yes, how many packs/day?
Have you ever smoked?	**Y/N**	
Do you drink alcohol?	**Y/N**	If yes, how many drinks/day?
Do you use any street drugs?	**Y/N**	If yes, describe:
Are you sexually active?	**Y/N**	

Do you have any problems with: Circle all that apply: If none to all, circle: **No to all**

Allergies	hay fever, hives
Heart	chest pain, rapid heart rate
General Health	chills, fever, weight gain, weight loss
Endocrine	cold/heat intolerance, excessive urination/thirst
Ears, Nose, Mouth	cough, discharge, dry mouth, ear pain, hearing loss, pain, stuffy nose
Gastrointestinal	constipation, diarrhea, nausea, vomiting
Genitourinary	blood, burning, increased frequency, incontinence
Blood/Lymph	bleeding, swelling, transfusions
Skin	bumps, changing moles, ulcers, rash, scalp tenderness
Muscle/Joint	pain, stiffness, swelling
Neurologic	dizziness, headache, imbalance, numbness, poor memory, weakness, confusion
Psychiatry	anxiety, depression, insomnia
Respiratory	congestion, shortness of breath, wheezing

Please answer the following questions: If none to all, circle: **No to all**

Are you allergic to adhesive?	Y/N
Are you allergic to lidocaine?	Y/N
Are you taking any blood thinners?	Y/N
Do you have a defibrillator?	Y/N
Are you taking Flomax?	Y/N
Do you have a pacemaker?	Y/N
Do you get rapid heart beat with epinephrine?	Y/N
Are you pregnant?	Y/N
Do you have any symptoms of Covid-19 virus or exposure to it	Y/N