Health and Vision History

- ☐Recent Fever/Chills
- ☐Weight Loss ☐Gain
- ☐ Jaw/Facial Pain

Cardiovascular
- ☐ High Blood Pressure
- ☐ Rapid/Irregular Heart Beat
- ☐ Coronary Artery Disease
- ☐ Artificial Heart Valve
- ☐ Pacemaker ☐Defibrillator
- ☐ Stroke
- ☐High Cholesterol

Ear, Nose and Throat
- ☐Hearing Loss
- ☐Ear Pain
- ☐Stuffy ☐ Runny Nose
- ☐Dry Mouth

Respiratory
- ☐Cough ☐Wheezing
- ☐ Sleep Apnea
- ☐Asthma
- ☐COPD

Gastrointestinal
- ☐Recent Upset Stomach
- ☐Recent Diarrhea ☐Constipation
- ☐Hepatitis Type
- ☐GERD (GastroEsophageal Reflux Disease)
- ☐IBS ☐Colitis

Musculoskeletal
- ☐Joint Pain ☐Stiffness
- ☐Arthritis ☐ Osteo ☐ Rheumatoid

Skin
- ☐Rash
- ☐ Rosacea
- ☐Lupus
- ☐Skin Cancer

Neurological
- ☐Headaches ☐ Migraines
- ☐Seizures
- ☐Stroke
- ☐ Multiple Sclerosis
- ☐Bell's Palsy
- ☐ Dementia ☐Alzheimer's

Psychiatric
- ☐Depression
- ☐Anxiety
- ☐Insomnia
- ☐PTSD
- ☐ADHD ☐ ADD

Endocrine
- ☐Diabetes ☐ Type 1 ☐ Type 2

★ Last A1C/Blood Sugars Number :

Date Taken:

- ☐Thyroid Abnormality ☐Hypo ☐ Hyper ☐ Hashimoto
- ☐Pituitary Disorder

Hematologic/Lymphatic
- ☐Anemia
- ☐ Sickle Cell Anemia/Trait

Allergic/Immunologic
- ☐Environmental Allergies (Plants/Animals)
- ☐ Adhesives, Tapes, Glues
- ☐Latex
- ☐Lidocaine
- ☐ Shellfish ☐ Iodine

☐***OTHER***

☐***Are You Pregnant?*** ***Due Date?***

☐ ***Do you use a computer?***

How Many hours Per Day?

Surgical History

Please list Major surgeries and Year

☐
☐
☐
☐

Were there any complications with anesthesia?

☐Yes☐No

Please Explain

Do you use Tobacco? ☐Yes ☐No ☐Former

☐Cigarettes ☐Pipe ☐Chewing Tobacco

How Much?

For how long?

Year Quit?

Do You Drink Alcohol? ☐Yes ☐No ☐Former

How many drinks per day/week?

Year Quit?

Type:

☐Beer ☐Wine ☐Hard Liquor

Do you use recreational drugs? ☐Yes ☐No ☐Former

What type?

Do you wear Contact Lenses? ☐Yes ☐No

☐Dailies ☐Bi-Weekly ☐Monthly ☐Gas Permeable

☐Spherical ☐Astigmatism ☐Multifocal ☐Monovision

Family History

What	*Self*	Mother	Father	Brother	Sister
☐Cataracts	☐	☐	☐	☐	☐
☐Macular Degeneration	☐	☐	☐	☐	☐
☐Retinal Disorder	☐	☐	☐	☐	☐
☐Blindness	☐	☐	☐	☐	☐
☐Glaucoma	☐	☐	☐	☐	☐
☐ Strabismus=Cross eyed	☐	☐	☐	☐	☐
☐Amblyopia=Lazy eye	☐	☐	☐	☐	☐
☐Cancer	☐	☐	☐	☐	☐
☐ Diabetes	☐	☐	☐	☐	☐
☐High Blood Pressure	☐	☐	☐	☐	☐
☐Cardiovascular Disease	☐	☐	☐	☐	☐

Medication Allergies *Reaction*

☐Penicillin

☐Sulfa

☐Codeine

☐Others

Medications

Please list all your current medications/Supplements

Medications *Dosage*