



## PATIENT HEALTH HISTORY

Patient Name: \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Email address: \_\_\_\_\_

Home Phone # \_\_\_\_\_ Other # \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

### MEDICAL HISTORY

•Are you allergic to any medications? Yes/ No If yes, please list: \_\_\_\_\_

•Are you currently taking any medications, including eye drops? Yes/ No  
If yes, please list: \_\_\_\_\_

•Have you taken any of the following medications in the last year?  
 Isotetinoin (Acutane) Yes/ No When? \_\_\_\_\_ How long taken? \_\_\_\_\_  
 Amiodarone (Codarone) Yes/ No When? \_\_\_\_\_ How long taken? \_\_\_\_\_  
 Sumitriptan (Imitrex) Yes/ No When? \_\_\_\_\_ How long taken? \_\_\_\_\_

•Do you have any known health conditions? Yes/ No If yes please list: \_\_\_\_\_

•Are you pregnant, nursing or planning a pregnancy in the near future? Yes/ No

•Do you or any of your family members have a history of:  
 Arthritis or connective tissue disease.....Y/N.....Self/Family  
 High Blood Pressure.....Y/N.....Self/Family  
 Keloid Formations (skin only).....Y/N.....Self/Family  
 Autoimmune disorder (lupus, thyroid).....Y/N.....Self/Family  
 Cold Sores (herpes virus).....Y/N.....Self/Family  
 HIV/AIDS.....Y/N.....Self/Family How long? \_\_\_\_\_  
 Hepatitis.....Y/N.....Self/Family How long? \_\_\_\_\_ Type? \_\_\_\_\_  
 Diabetes .....Y/N.....Self/Family How long? \_\_\_\_\_ Insulin Y/N

### OCULAR HISTORY

•Do you or any of your family members have a history of:  
 Glaucoma.....Y/N.....Self/Family Lazy Eye.....Y/N..Self/Family  
 Dry Eye.....Y/N.....Self/Family Diabetic Retinopathy...Y/N..Self/Family  
 Herpes (eye).....Y/N.....Self/Family Retinal tear/detachment...Y/N...Self/Family  
 Trauma (eye).....Y/N.....Self/Family Macular Degeneration.....Y/N...Self/Family  
 Eye Surgery.....Y/N.....Self/Family \_\_\_\_\_

### CONTACT LENS WEAR

•Have you ever worn contact lenses? Yes/ No

•Do you currently wear contact lenses? Yes/ No

•If you answered yes to either of these questions, please indicate any type of contact lenses worn:

Soft Extended Wear	Soft Daily Wear
Disposable	Soft Toric
Hard	Rigid Gas Permeable

•How long have you worn contact lenses? \_\_\_\_\_

•When did you last wear contact lenses? \_\_\_\_\_