

HEALTH HISTORY FORM

YES NO HEART DISEASE

YES NO HEAD OR SPINAL INJURIES

YES NO HEART ATTACK OR ANGINA

YES NO PERMANENT DEFECT FROM ILLNESS, DISEASE OR INJURY

YES NO HIGH BLOOD PRESSURE

YES NO MUSCLE DISEASE

YES NO COPD OR Asthma

YES NO TEMPORAL ARTERITIS

YES NO DIABETES NON-INSULIN OR INSULIN DEPENDANT

YES NO ARTHRITIS OR LIMITED MOVEMENT

YES NO KIDNEY DISEASE

YES NO CAROTID ARTERY DISEASE

YES NO LIVER DISEASE OR HEPATITIS

YES NO PSYCHIATRIC DISORDER

YES NO ULCER

YES NO ARE YOU PREGNANT (WOMEN)

YES NO STROKE OR TIA

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

YES NO SEIZURES, CONVULSIONS OR FAINTING

YES NO HIV

YES NO ARE YOU TAKING OR HAVE YOU TAKEN SABRIL?

YES NO DO YOU SMOKE? # OF PACKS PER DAY _____ # PACKS PER WEEK _____
QUIT _____ WHEN? _____

YES NO ARE YOU USING LATISSE?

YES NO DO YOU DRINK? # OF DRINKS PER DAY _____ # OF DRINKS PER WEEK _____

YES NO MEASLES OR MUMPS OR CHICKEN POX?

• HEIGHT _____ WEIGHT _____

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• GENERAL SURGICAL HISTORY: _____

• PROBLEMS WITH ANESTHESIA? YES ___ NO ___ IF YES, WHAT REACTION? _____

OCULAR HISTORY:

YES NO CATARACTS

YES NO CORNEA DISEASE

YES NO RETINA DISEASE

YES NO GLAUCOMA

YES NO CROSSED EYES OR LAZY EYE

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

YES NO IRITIS

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 RELATIVES) 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 HEART PROBLEMS _____

YES NO CATARACTS _____

YES NO DIABETES OR DIABETIC RETINOPATHY _____

YES NO CORNEA DISEASE _____

YES NO RETINAL DETACHMENT _____

YES NO MACULAR DEGENERATION _____

YES NO STROKE _____

YES NO ALZHEIMERS OR DEMENTIA _____

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: _____
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_____ REASON FOR TAKING: _____
_____ REASON FOR TAKING: _____
_____ REASON FOR TAKING: _____

PRIMARY CARE PHYSICIAN:

PATIENT SIGNATURE: _____ DATE: _____

For office use only


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Daniel Behn O.D.

PATIENT
NAME: _____ DOB: _____ DATE: _____