PT. #____________________

California EYE PROfessionals MEDICAL GROUP, INC.

# 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: ______________