SHIPP EYE CLINIC

Pt Name: _____

Date: _____

Health History

Last Medical Exam: ___/___/___ Primary Care Doctor: _____ Height: _____

Last Eye Exam: ___/___/___ Referring Doctor: _____ Weight: _____

List all your medications you currently take (prescription, over-the-counter, herbal, vitamins): ☐ none

_____

_____

_____

EYE HISTORY:

Have you been diagnosed with any of the following?

Cataracts	☐Yes ☐No	_____	Eye Injury	☐Yes ☐No	_____
Corneal Disease	☐Yes ☐No	_____	Iritis	☐Yes ☐No	_____
Crossed eyes	☐Yes ☐No	_____	Lazy eye	☐Yes ☐No	_____
Diabetic retinopathy	☐Yes ☐No	_____	Retinal detachment	☐Yes ☐No	_____
Dry eyes	☐Yes ☐No	_____	Retinal disease	☐Yes ☐No	_____
Eye Infections	☐Yes ☐No	_____	Other eye disorders	☐Yes ☐No	_____

Have you ever had problems in the following areas?

Loss of Vision	☐Yes ☐No	_____	Redness	☐Yes ☐No	_____
Distorted Vision	☐Yes ☐No	_____	Itching	☐Yes ☐No	_____
Blurred Vision	☐Yes ☐No	_____	Burning	☐Yes ☐No	_____
Double Vision	☐Yes ☐No	_____	Sandy or Gritty	☐Yes ☐No	_____
Glare	☐Yes ☐No	_____	Foreign Body Sens.	☐Yes ☐No	_____
Light sensitivity	☐Yes ☐No	_____	Tearing/Watering	☐Yes ☐No	_____
Halos on Lights	☐Yes ☐No	_____	Eye Pain	☐Yes ☐No	_____

FAMILY HISTORY:

Has anyone in your family (blood relative) had any of the following conditions?

Blindness	☐Yes ☐No	_____	Arthritis	☐Yes ☐No	_____
Cataracts	☐Yes ☐No	_____	Cancer	☐Yes ☐No	_____
Corneal Disease	☐Yes ☐No	_____	Diabetes	☐Yes ☐No	_____
Crossed Eyes	☐Yes ☐No	_____	Heart Disease	☐Yes ☐No	_____
Glaucoma	☐Yes ☐No	_____	Kidney Disease	☐Yes ☐No	_____
Macular Degen.	☐Yes ☐No	_____	Lupus	☐Yes ☐No	_____
Retinal Detachment	☐Yes ☐No	_____	Thyroid Disease	☐Yes ☐No	_____

_____ _____

Signature of Patient Date Signature of Doctor Date

SHIPP EYE CLINIC

Pt Name: _____

Date: _____

Health History (cont.)

MEDICAL HISTORY:

Have you been diagnosed with any of the following?

Asthma	☐Yes	☐No	_____	High blood press.	☐Yes	☐No	_____
Allergies	☐Yes	☐No	_____	HIV/AIDS	☐Yes	☐No	_____
Anemia	☐Yes	☐No	_____	Kidney disease	☐Yes	☐No	_____
Autoimmune dz	☐Yes	☐No	_____	Gout	☐Yes	☐No	_____
Cancer	☐Yes	☐No	_____	Joint/muscle pain	☐Yes	☐No	_____
Chronic cough	☐Yes	☐No	_____	Migraines	☐Yes	☐No	_____
Constipation	☐Yes	☐No	_____	Psychiatric disease	☐Yes	☐No	_____
COPD/Emphysema	☐Yes	☐No	_____	Rheumatoid arthritis	☐Yes	☐No	_____
Diabetes(# years?)	☐Yes	☐No	_____	Seizures/fainting	☐Yes	☐No	_____
Diarrhea	☐Yes	☐No	_____	Sleep apnea/CPAP	☐Yes	☐No	_____
Dry mouth/throat	☐Yes	☐No	_____	Stroke	☐Yes	☐No	_____
Heart disease	☐Yes	☐No	_____	Thyroid disease	☐Yes	☐No	_____
Hepatitis	☐Yes	☐No	_____	Other	☐Yes	☐No	_____

SOCIAL HISTORY:

Do you use tobacco products?	☐Yes	☐No	_____
Do you drink alcohol?	☐Yes	☐No	_____
Do you use illegal drugs?	☐Yes	☐No	_____

SURGICAL HISTORY:

Have you had any type of surgical procedure in the past?

_____

_____

_____

ALLERGIES:

Do you have any allergies to medications?	☐Yes	☐No	_____
Do you have any allergies to latex?	☐Yes	☐No	_____
Do you have any allergies to betadine?	☐Yes	☐No	_____

_____ _____

Signature of Patient Date Signature of Doctor Date