Aurora EYE CLINIC

HEALTH HISTORY

Patient Name ______________________ Date ______________________

Primary Care Physician ______________________ Referring Physician ______________________

Please indicate if you currently or have had any of the following medical conditions:

- ☐ Asthma
- ☐ Brain tumor
- ☐ Cancer *(type/location)*______________________
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Heart attack
- ☐ Head Injuries
- ☐ Headache
- ☐ Heart disease
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Prostate disease
- ☐ Rheumatoid disease
- ☐ Seizures
- ☐ Thyroid disease
- ☐ Currently pregnant or nursing
- ☐ Other:______________________

Please indicate if you currently have past and/or present eye conditions:

- ☐ Blepharitis
- ☐ Diabetic retinopathy
- ☐ Glaucoma
- ☐ Lazy eye
- ☐ Cataract
- ☐ Double vision
- ☐ Iritis
- ☐ Macular degeneration
- ☐ Corneal transplant
- ☐ Eye injury
- ☐ LASIK/PRK/RK
- ☐ Retinal detachment

Please list any past eye surgeries or laser treatments:

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Please list all medications you are currently taking:

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Do you have allergies, reactions to medications or problems with anesthesia? ☐ Yes ☐ No
If yes, please describe:

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Social History

Alcohol	☐ None	☐ Rarely	☐ Occasionally
Tobacco *(cigarettes, cigars, chew)*	☐ Never	☐ Former (year quit:_______)	☐ Current (years used: ____)
Recreational drug use	☐ Never	☐ Former	☐ Current

Family History

	Father	Mother	Sibling(s)
Blindness	☐	☐	☐
Diabetes	☐	☐	☐
Glaucoma	☐	☐	☐
Macular degeneration	☐	☐	☐
Muscle disorders of the eye	☐	☐	☐
Retinal detachment	☐	☐	☐