Health History

Name:_____ **Date:**_____

Thank you for choosing Tulsa Eye Associates for your eyecare. To better serve you, please answer the following questions:

	Yes	No
1. Do you wear glasses?	☐	☐
2. Do you wear contact lenses?	☐	☐
3. Do you have problems reading?	☐	☐

4. Are you currently experiencing any eye symptoms?

Eye Pain	Blurred Vision	Eyelid Crusting	Flashes of Light	Halos
Discharge	Light Sensitivity	Double Vision	Decreased Vision	Floaters

5. Have you ever had an eye injury? _____

_____

6. Have you ever had an eye surgery? Please list type, which eye and approximate dates:

_____ R/L _____ R/L

_____ R/L _____ R/L

7. Surgeries not related to the eyes?

_____ _____

_____ _____

8. Are you currently using any eye drops? Please list name and how often used:

_____ _____

_____ _____

_____ _____

9. Are you being treated for any medical conditions? Please circle all that apply:

Diabetes Heart Disease High Blood Pressure High Cholesterol

Stroke Arthritis Asthma Cancer:_____

Other:_____

10. What prescription or over the counter medications are you currently taking?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

11. Are you allergic to any medications? Please List:_____

_____

12. Do you have any family history of eye problems? Please list family relationship:

Glaucoma:_____ Retinal Disease:_____

Cataract:_____ Macular Degeneration:_____

Diabetes:_____ High Blood Pressure:_____

Arthritis:_____ Cancer:_____

Other:_____

13. Smoking or Tobacco status: (Circle One)

Former / Current / Never

Date Stopped:_____

14. Alcohol status: (Circle One)

Social / Everyday / Never