INSIGHT VISION GROUP

HEALTH HISTORY

Name _____ **Age** _____ **Date**_____

Chief Problem _____

Other Medical Providers _____

Known Eye Problems:	**R**	**L**	**Onset**	**Previous Eye Surgery:**
□ Cataracts	___	___	_____	Right Eye_____
□ Injury	___	___	_____	_____
□ Farsighted/Nearsighted	___	___	_____	_____
□ Lazy Eye	___	___	_____	
□ Retinal Disease	___	___	_____	Left Eye_____
□ Corneal Disease	___	___	_____	_____
□ Glaucoma	___	___	_____	_____

Present Eye Medications:

Name (circle)	Year Started	Which Eye(s)	How Often Per Day	Used Before?	Allergy to Med?
Alphagan (P)/Brimonidine	_____	R L Both	1 2 3 4	Y N	_____
Azopt	_____	R L Both	1 2 3 4	Y N	_____
Betagan (levobunolol)	_____	R L Both	1 2 3 4	Y N	_____
Betaxolol or Carteolol	_____	R L Both	1 2 3 4	Y N	_____
Combigan	_____	R L Both	1 2 3 4	Y N	_____
Cosopt	_____	R L Both	1 2 3 4	Y N	_____
Diamox or Neptazane Pill	_____	R L Both	1 2 3 4	Y N	_____
Dipivefrin (Propine)	_____	R L Both	1 2 3 4	Y N	_____
Doxycycline Pill	_____	R L Both	1 2 3 4	Y N	_____
Lumigan	_____	R L Both	1 2 3 4	Y N	_____
Ocupress/OptiPranolol	_____	R L Both	1 2 3 4	Y N	_____
Ointment:_____	_____	R L Both	1 2 3 4	Y N	_____
Pilocarpine (GEL?)	_____	R L Both	1 2 3 4	Y N	_____
Restasis	_____	R L Both	1 2 3 4	Y N	_____
Steroid Eye Drop	_____	R L Both	1 2 3 4	Y N	_____
Timoptic/Timolol	_____	R L Both	1 2 3 4	Y N	_____
Travatan	_____	R L Both	1 2 3 4	Y N	_____
Xalatan	_____	R L Both	1 2 3 4	Y N	_____
Vigamox/Zymar	_____	R L Both	1 2 3 4	Y N	_____
Other:_____	_____	R L Both	1 2 3 4	Y N	_____
Other:_____	_____	R L Both	1 2 3 4	Y N	_____

Please List All Allergies_____

_____

_____

Active Medical Problems:

□ Asthma
□ Diabetes
□ High Blood Pressure
□ Heart Disease
□ Stroke
□ Migraines
□ TB
□ Hepatitis
□ HIV
□ Seizures
□ Blood Disorder
□ Psychiatric Condition
□ Nervous Condition
□ Temporal Arteritis
□ Arthritis
□ Skin Disorder

Additional History:

Do you smoke?
Y N
Do you drink alcohol?
Y N
Any occupational hazard exposure?
Y N
Do you drive?
Y N
Do you have visual problems driving?
Y N
Do you have night vision problems?
Y N
Have you had a blood transfusion?
Y N

Family History:

(please note family member
F=father, M=mother, S=sister
B=brother, C=child, A=aunt, U=uncle
GP=grandparent, O=other)

□ Glaucoma _____
□ Cataracts _____
□ Corneal Disease _____
□ Retinal Disease _____
□ Diabetes _____
□ Heart _____
□ Stroke _____
□ Cancer _____
□ Other: _____
_____

Please List Current General Medications_____

_____

_____

_____

Other Medical and Surgical History: (please write out any problems and year it occurred)

_____

_____

_____

_____

System Review: (circle symptoms that apply to you)

General: fatigue weight loss fevers chills tired

Skin: rash blisters dry patches spots

Nose, Ear, Throat: nasal drip sinus infections poor hearing sore throat dry mouth missing teeth

Heart: palpitations chest pain short of breath sleep with head elevated irregular heartbeat

Lungs: cough wheezing gasping pneumonia

Abdomen: stomach pain diarrhea bleeding pain tenderness

Muscles: weak lifting arms or climbing steps no strength

Bones: osteoporosis joint pain easy fractures

Genito-urinary: kidney stones burning with urination incontinence pregnant

Nervous system: tremor imbalance