HEALTH HISTORY
Liberty Ophthalmology

Date of Last Eye Exam_____

Previous Eye Doctor _____

Do you wear glasses? □ No □ Yes □ Reading □ Driving

Do you wear contacts? □ Yes □ No

CL type_____

Do any of the following
eye diseases run in your family?
□ Macular Degeneration □ Glaucoma
□ Retinal Hole, Tear, or Detachment

Mark "Yes" or "No" to indicate if you have any of the following. Mark the box if a blood relative has had any of the following.

	Yourself		Family		Yourself		Family
AIDS/HIV	☐ Yes	☐ No	☐	Heart Disease	☐ Yes	☐ No	☐
Arthritis Type _____	☐ Yes	☐ No	☐	Hepatitis Type _____	☐ Yes	☐ No	☐
Artificial Heart Valve	☐ Yes	☐ No	☐	High Blood Pressure	☐ Yes	☐ No	☐
Artificial Joints _____	☐ Yes	☐ No	☐	Kidney Disease	☐ Yes	☐ No	☐
Asthma	☐ Yes	☐ No	☐	Lazy Eye / Amblyopia	☐ Yes	☐ No	☐
Auto-Immune Disease Type_____	☐ Yes	☐ No	☐	Migraine Headaches	☐ Yes	☐ No	☐
Bleeding	☐ Yes	☐ No	☐	Pacemaker/Defibrillator	☐ Yes	☐ No	☐
Blindness	☐ Yes	☐ No	☐	Poor Color Vision	☐ Yes	☐ No	☐
Cancer Type _____	☐ Yes	☐ No	☐	Retinal Disease	☐ Yes	☐ No	☐
Cataracts? Surgery ☐ Year _____	☐ Yes	☐ No	☐	Rheumatic Fever	☐ Yes	☐ No	☐
Chemical Dependency	☐ Yes	☐ No	☐	Shingles	☐ Yes	☐ No	☐
Diabetes Years _____ HgA1C _____	☐ Yes	☐ No	☐	Skin Condition	☐ Yes	☐ No	☐
Drug Sensitivity	☐ Yes	☐ No	☐	Stroke	☐ Yes	☐ No	☐
Emphysema or COPD	☐ Yes	☐ No	☐	Tobacco use	☐ Yes	☐ No	☐
Epilepsy	☐ Yes	☐ No	☐	Thyroid Condition	☐ Yes	☐ No	☐
Eye Surgery Type _____	☐ Yes	☐ No	☐	Turned Eye	☐ Yes	☐ No	☐
Glaucoma	☐ Yes	☐ No	☐				
Hay Fever/ Seasonal Allergies	☐ Yes	☐ No	☐				

Are you pregnant? N Y Number of children_____

OTHER_____

OTHER_____

OTHER _____

Primary Care Physician _____ Phone _____

Medications (if none please state so)

_____

_____

_____

EYE MEDICATIONS_____

ALLERGIES (If none please state so)

_____

_____

Date _____ Reviewed _____ Reviewed _____ Reviewed _____ Reviewed _____