HISTORY WORKSHEET

Name: _____ **Date of Birth:** _____ **Date:** _____

****** DO YOU WEAR ESSENTIAL OILS?**_____

OCULAR HISTORY

Pharmacy:_____
Date of last eye exam: _____
Place/Doctor:_____
Ever worn contact lenses? Yes No
Ever had eye surgery? Yes No
If yes, date: _____
Surgeon: _____
What type of surgery: _____
List any eye medications, (including over-the-counter)**:**

_____
_____

Do you have any history of the following?

__Cataract __Diabetic Eye Disease
__Glaucoma __Blindness
__Lazy Eye __Macular Degeneration
__Strabismus __Retinal Detachment
__Other eye conditions such as eye trauma

_____

FAMILY HISTORY

Any ocular conditions in your family?

__Cataract __Diabetic Eye Disease
__Glaucoma __Retinal Detachment
__Crossed Eyes __Macular Degeneration
__Blindness

Any medical conditions in your family?

__Asthma/COPD __Heart Disease
__Cancer __Diabetes
__Migraine __Low Blood Pressure
__Arthritis __High Blood Pressure
__Stroke/TIA

List any other significant eye or general problems in your family:_____

_____
_____
_____
_____

MEDICAL/SOCIAL HISTORY

Family Doctor name:_____
Phone:_____
Location:_____
Do you have any of these medical conditions?

__Asthma __Heart disease __Cancer
__COPD __Migraine __Stroke/TIA
__Sleep apnea __Steroid use __HIV
__Arthritis __High blood pressure
__Kidney Disease __Low blood pressure
__Thyroid __Hepatitis/Liver disease
__High cholesterol __Psychiatric disease
__Diabetes __Heart Attack

List any surgeries you have had on your body, excluding your eyes, with dates:_____

_____
_____
_____

Do you consume alcohol? YES NO
If yes, how many drinks per week on average?____
Do you smoke? YES NO
Have you ever used recreational drugs? YES NO
What is your occupation?_____
If retired, previous occupation:_____

MEDICATIONS

List all medications you are taking:

_____
_____
_____
_____
_____
_____
_____
_____
_____

List any over-the-counter medications/herbals/supplements:

_____
_____
_____
_____
_____

List any medication allergies:

_____
_____
_____

Any other types of allergies:

_____