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):

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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

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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:_______________

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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:_______________

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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:

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

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List any medication allergies:

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Any other types of allergies:

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