# HISTORY WORKSHEET

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

**Please indicate here if you are under Pain Management ____YES (Physician_____) ____NO**

## 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 <u>eye</u> 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 __Diabetes
__COPD __Heart Disease
__Cancer __Low Blood Pressure
__Migraine __High Blood Pressure
__Arthritis
__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: Please include dosage(s).**

_____

_____

_____

_____

_____

_____

_____

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

_____

_____

**Using CBD Oil: _____YES _____NO**

**List any medication allergies:**

_____

_____

**Any other types of allergies:**

_____

_____

**Patient Signature** **Date**