NEW YORK
CATARACT & LASER EYE CARE, P.C.

HEALTH HISTORY FORM

Name of Patient: _____ Phone#: _____Date of Birth: _____
(last) (first) (MI)
Address: _____ City: _____ State: _____ Zip: _____

Who referred you to this office? _____ Physician's Name: _____

Email_____ Person filling out this form: SELF or _____

Today's Eye Problem: _____

When did the problem start? _____Is it still present? Yes or No If no, how long did it last? _____

HEALTH HISTORY (Check those that apply)

Eye Diseases	Impairments	Chronic or Recurring Illness	Allergies	
—— Cataract	—— Difficulty reading a book	—— Sleep Apnea	—— Medication*	—— Hearing Loss
—— Macular Degeneration	—— Difficulty reading at a distance	—— Heart Disease	—— Seasonal	—— Hearing Aid
—— Glaucoma	—— Double vision	—— Seizures	—— Other	—— Contact Lenses
—— Diabetic Retinopathy	—— Severe eye pain	—— Bleeding Disorders	——	—— Other:
—— Retinal Diseases	—— Glare from bright lights	—— Asthma	——	_____
—— Cornea Disease	—— Other	—— High Blood Pressure	_____	
____ Dry Eye	——	—— Diabetes		
____ Other	——	—— Musculoskeletal Disorders		
		—— Other (Specify):		

Explain: _____

*** If yes, which medications?**

Family History (please circle all that apply)

Glaucoma, Retinal problems, "Lazy Eye", Heart Disease, Diabetes, High Blood Pressure, Migraine, Arthritis, Stroke

Medication List (Please list all Prescription and Over-the-Counter medication)

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