

**Awad Eye Care, LLC**  
**General Health History**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Family Physician: \_\_\_\_\_

**Current Problems:** Do you currently have any of the following problems?

<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Ears/mouth/nose/throat	<input type="checkbox"/>	<input type="checkbox"/>	Reaction to anesthetics
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<i>Asthma or emphysema</i>
<input type="checkbox"/>	<input type="checkbox"/>	Sinus disease	<input type="checkbox"/>	<input type="checkbox"/>	Other lung disease
<input type="checkbox"/>	<input type="checkbox"/>	<i>High blood pressure</i>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/neurological disease
<input type="checkbox"/>	<input type="checkbox"/>	<i>Irregular heart beat</i>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health problems
<input type="checkbox"/>	<input type="checkbox"/>	<i>Other heart disease</i>	<input type="checkbox"/>	<input type="checkbox"/>	Blood or bleeding disorders
<input type="checkbox"/>	<input type="checkbox"/>	<i>Diabetes, how long?</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Smoking <input type="checkbox"/> Non-Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

---

**Medications:** Please list all medications that you take

\_\_\_\_\_

\_\_\_\_\_

**Allergies:** Please list all allergies to medicine that you have and the reaction that it causes

\_\_\_\_\_

\_\_\_\_\_

**Illness/injuries:** Please list all past major illnesses or injuries that you have had.

\_\_\_\_\_

\_\_\_\_\_

**Family History:** Please list major medical conditions that affect your parents, siblings or children

\_\_\_\_\_

\_\_\_\_\_

**Eye Diseases:** Do you now, or have you ever had, any of the following eye disease?

Yes	No	Which eye?	R	L	Yes	No	Which eye?	R	L	
<input type="checkbox"/>	<input type="checkbox"/>	Cataract	___	___	<input type="checkbox"/>	<input type="checkbox"/>	Crossed eyes	___	___	
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	___	___	<input type="checkbox"/>	<input type="checkbox"/>	Lazy eye	___	___	
<input type="checkbox"/>	<input type="checkbox"/>	Detached retina	___	___	<input type="checkbox"/>	<input type="checkbox"/>	Injury	_____		
<input type="checkbox"/>	<input type="checkbox"/>	Macular degeneration	___	___	<input type="checkbox"/>	<input type="checkbox"/>	Other	_____		

---

**Glasses and Contact Lenses:** Do you currently wear glasses or contact lenses?

Glasses for distance     Glasses for reading     Rigid contact lens     Soft contact lens

---

**Family Eye History:** Have any of your parents, siblings, or children had any of the following eye diseases?

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Cataract	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Lazy eye	<input type="checkbox"/>	<input type="checkbox"/>	Detached retina
<input type="checkbox"/>	<input type="checkbox"/>	Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Blindness

---

**History Updates**

_____	date	changes	Dr.'s Initials
Doctor's signature	_____	_____	_____
	_____	_____	_____