



## HEALTH HISTORY

Date of Last Eye Examination \_\_\_\_\_ Dr. \_\_\_\_\_

Date of Last Physical Exam \_\_\_\_\_ Dr. \_\_\_\_\_

Does any Blood Relative have a history of the following?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Cataracts        | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Thyroid Dysfunction | <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> _____                |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Retinal Problems |   |

Please check any of the following that apply to you, The Patient:

- |   |   |                                  |
|---|---|----------------------------------|
| <input type="checkbox"/> Allergies (Non-Drug) | <input type="checkbox"/> Frequent Headaches       | <input type="checkbox"/> Nursing |
| <input type="checkbox"/> Sinus                | <input type="checkbox"/> Pregnant                 | <input type="checkbox"/> _____   |
| <input type="checkbox"/> Hayfever             | <input type="checkbox"/> Allergies to Medications |                                  |

Have YOU ever HAD or do you CURRENTLY experience any of the following conditions affecting your eyes?

- |                                      |  |  |
|--------------------------------------|--|--|
| <input type="checkbox"/> Eye Injury  | <input type="checkbox"/> Eye Pain          | <input type="checkbox"/> Blackouts or Dimness      |
| <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Double Vision     | <input type="checkbox"/> Eyes Burn, Itch, or Water |
| <input type="checkbox"/> Eye Disease | <input type="checkbox"/> Spots or Floaters | <input type="checkbox"/> _____                     |
| <input type="checkbox"/> Eye Fatigue | <input type="checkbox"/> Flashes of Light  |  |

Yes                      No

- |   |                          |                          |
|---|--------------------------|--------------------------|
| Do you have any known health problems? .....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you take any pills, medications, or oral contraceptives? .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear glasses? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear or have you ever worn contact lenses? .....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| If "NO", are you interested in wearing contact lenses? .....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| If you are over 18 years of age, are you interested in Lasik Eye Surgery? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| What hobbies or sports do you participate in? _____                             |                          |                          |

## AUTHORIZATION

I certify that I have read and understand the questions listed on this form. All the questions have been accurately answered to the best of my knowledge. I authorize Dr. Godich to release the records of any eye treatment rendered to me or my child to third party payors and/or health care practitioners. I also authorize my insurance benefits, if applicable, be paid directly to Dr. Godich, and I understand I am financially responsible for non-covered charges.

\_\_\_\_\_  
Signature of Patient (Or Parent, If A Minor)

\_\_\_\_\_  
Date