Joseph Decker, M.D., F.A.C.S.
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SAN JOSE EYE INSTITUTE

HEALTH HISTORY

Patient Name ______________________________

Pharmacy Name ____________ Pharmacy Address ____________________ Pharmacy Zip Code ________

Place a mark on "Yes" or "No" to indicate if you have or use any of the following:

Condition	Yes	No
Eye pain	☐ Yes	☐ No
Eye redness	☐ Yes	☐ No
Decreased vision	☐ Yes	☐ No
Loss of vision	☐ Yes	☐ No
Excessive tearing	☐ Yes	☐ No
Scalp tenderness	☐ Yes	☐ No
Jaw pain	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Exacerbation of allergies	☐ Yes	☐ No
Increased anxiety	☐ Yes	☐ No
Joint pain	☐ Yes	☐ No
Poor control of blood pressure	☐ Yes	☐ No
Poor control of blood sugar	☐ Yes	☐ No
Blood thinners	☐ Yes	☐ No

Are you pregnant? ☐ Yes ☐ No Number of children ______

Tobacco use ____________ Alcohol use ____________

Condition	Yes	No
Flomax use (past or present)	☐ Yes	☐ No
Defibrillator	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Unexplained weight loss	☐ Yes	☐ No
Nasal congestion	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Upset Stomach	☐ Yes	☐ No
Artificial heart valve	☐ Yes	☐ No
Artificial joints	☐ Yes	☐ No
Allergy to adhesives	☐ Yes	☐ No
Allergy to Lidocaine	☐ Yes	☐ No
MRSA	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No

Is there a family history of diabetes or any eye diseases / conditions? If so, please list family members and details:

☐ None ______________________________

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MEDICATIONS

List your current medications, including eye drops.

☐ None ______________________________

____
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____
____
____
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ALLERGIES

List your allergies to medications or other substances.

☐ None ______________________________

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