ENVISION
EYE & AESTHETICS
THE BEST VERSION OF YOU

Health History

Name: _____ **DOB:** _____ **Age:** _____

Please List all Medical Diagnoses you have or have had

_____

_____

_____

_____

_____

Please list any eye conditions you have (for example: Macular degeneration, Glaucoma, floaters, etc including any eye surgeries)

_____

_____

Please list all medications including any supplements (include dose and frequency):

Medication [ ] list attached	Dose	Frequency	Route

(You may list additional medications on the back side of this form)

Allergies to Medications /Anesthesia/ Latex / Adhesives / Foods (include reaction to medication):

_____
_____
_____

Are you a smoker or a former smoker? if so, please indicate how many years you smoked and on average how many cigarettes a day:

_____

Do you exercise: Y / N What and how often? _____

Do you drink alcohol? If so, how much and how often?

_____

Do you require antibiotics before surgery (dental or any)? Y / N
If yes, explain _____

List all previous surgeries:

_____
_____
_____

Do you have or have you ever had any of the following medical problems:

Anxiety	**Y / N**	**Hepatits**	**Y / N**
Arthritis	**Y / N**	**High Blood Pressure**	**Y / N**
Asthma	**Y / N**	**HIV / AIDS**	**Y / N**
Irregular Heartbeat	**Y / N**	**Hyperthyroid**	**Y / N**
Bone Marrow Transplant	**Y / N**	**Hypothyroid**	**Y / N**
Breast Cancer	**Y / N**	**Leukemia**	**Y / N**
Colon Cancer	**Y / N**	**Lung Cancer**	**Y / N**
COPD	**Y / N**	**Lymphoma**	**Y / N**
Heart/ Artery Disease	**Y / N**	**Prostate Cancer**	**Y / N**
Depression	**Y / N**	**Other Cancer**	**Y / N**
Mental Concerns	**Y / N**	**Radiation**	**Y / N**
End Stage Renal Disease	**Y / N**	**Seizures**	**Y / N**
GERD	**Y / N**	**Stroke**	**Y / N**
Hearing Loss	**Y / N**	**Diabetes**	**Y / N**
Prob Nerves/Muscles	**Y / N**	**Bruising or Bleeding**	**Y / N**
Problem Healing	**Y / N**	**Abnormal Scarring**	**Y / N**
Active Infection	**Y / N**	**Blood Clots**	**Y / N**
Hx Urinary Infection	**Y / N**	**Hx Vaginal Infection**	**Y / N**

Please list any medical conditions your mother, father or close family members have:

_____
_____

For diVa Patients Only:

Last Pelvic Exam _____, Last Pap Smear _____,
Hx of Genital Cold Sores or Herpes? _____, Last Mammogram _____,
Hx of abnormal mammogram?_____

Past OB/Gyn surgeries/procedures: _____
_____

Menstrual History:

Age at First Period _____, Menstrual cycles regular Y / N, Every _____ days,
How long do they last? _____, Bleeding between periods? Y / N,
Bleeding after intercourse? Y / N, Hx STD? _____ Pain with Periods? Y / N
Describe _____

Sexual Partner Y / N, Male, Female

Pregnancy History:

# of Pregnancies _____, Live Births _____, Miscarriages/Stillborn _____,
Abortions _____, Vaginal Deliveries _____, Cesarean Sections _____

Contraception: Y N Describe what method and how long _____
_____

Do You Have:

Hot Flashes Y / N, Vaginal Dryness Y / N, Night Sweats Y / N, Painful intercourse Y / N,
Urine Leakage Y / N Describe _____
Other Concerns _____