Chili Vision Group
Patient Health and Ocular History

Name: _____ Date: _____

General Health

Diabetes Y / N	Patient / Family _____
Hypertension Y / N	Patient / Family _____
Asthma or Emphysema Y / N	Patient / Family _____
Thyroid Disease Y / N	Patient / Family _____
Heart Disease Y / N	Patient / Family _____
Stroke Y / N	Patient / Family _____
Arthritis (Osteo / Rheumatoid) Y / N	Patient / Family _____
Multiple Sclerosis Y / N	Patient / Family _____
Cancer Y / N	Patient/ Family _____
Autoimmune Disease Y / N	Details: _____
Trauma or surgery to head or neck Y / N	
Pregnant Y / N	Patient / Family _____
Developmental Delay or Disability Y / N	Patient / Family _____
Neurological Disorders Y / N	
Other:	

Ocular Health

Cataract Y / N	Patient/ Family _____
Glaucoma Y / N	Patient/ Family _____
Retinal Disease Y / N	Patient/ Family _____
Macular Degeneration: Wet or Dry Y / N	Patient/ Family _____
Blindness Y / N	Patient/ Family _____
Surgery Y / N	Patient/ Family _____
Trauma Y / N	Patient/ Family _____
Other:	

Reviewed By: _____ Date:_____
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