NAME (Mr./Mrs./Ms./Dr.) _____ Date of Birth: _____ Date: _____

Medical History

Do you have…

Diabetes? Yes/No How many years?_____ Treatment Medication? _____

High blood pressure? Yes/No How many years?_____ Treatment Medication? _____

High cholesterol? Yes/No How many years?_____ Treatment Medication? _____

Medication allergies? Yes/No Please list: _____

Other Medications: (Please list any and all medications including eye drops, over the counter, and homeopathic remedies:

_____

_____

Are you under any medical treatment? Yes/No For?_____

Primary Care Provider: Dr._____ Phone:_____ Last Medical Exam:_____

Females: Are you pregnant/nursing? Yes/No

List any **major injuries, surgeries & hospitalizations** you have had:

_____

_____

Personal medical conditions -- *circle* *all that apply*	***Current* Eye Symptoms -- *circle*** all that apply
Fever, Weight or appetite loss (Constitutional)	Sudden Vision Loss
Skin conditions, disorders (Integumentary)	Blurred Vision
Headache, Migraine, Seizures (Neurological)	Loss of Side Vision
Thyroid/ Endocrine gland problems (Endocrine)	Double Vision
Allergies, Dry Mouth/Throat (Ear, Nose Throat)	Floaters
Asthma, COPD, Emphysema (Respiratory)	Flashes of light in vision
Stroke, Heart Attack (Vascular)	Mucus Discharge
Diarrhea, Constipation (Gastrointestinal)	Redness, Sandy or Gritty
Genitals, Kidneys, Bladder (Genitourinary)	Itchy, burning, Tearing/Watery
Rheumatoid Arthritis, Muscle Pain (Bones/Joints)	Glare or Halos at night
Anemia, Bleeding (Lymphatic/ Hematologic)	
Lupus, Multiple Sclerosis (Immunologic)	**Do you have? -- *circle*** all that apply
HIV/TB other (Infectious Diseases)	Glaucoma
Depression/Anxiety (Psychiatric)	Macular Degeneration
Other health conditions:	History of uveitis
	Other eye conditions?
	History of eye injury?

Personal Social History: (*ALL information is strictly confidential, you may discuss this part with the doctor*)

Do you Drive? Yes/No Do you use tobacco product? Yes/No How many years?____

Any difficulty driving? Yes/No Use of alcohol product? Yes/No

Use of Illicit drugs? Yes/No

Family Eye and Medical History (*circle* *all that apply*)	**Relationship to you**
Blindness	
Glaucoma	
Macular Degeneration	
Retinal Disease (retinitis pigmentosa, retinal detachment)	
Cataracts	
Cancer (list type)	
Diabetes	
High Blood Pressure	
Heart Disease	
Kidney Disease	
Thyroid Disease	
Other?	