MEDICAL HISTORY

Patient Name _____ DOB _____

OCULAR MEDICAL HISTORY

Glaucoma	Yes ☐ No ☐	Crossed Eyes	Yes ☐ No ☐	Blurred Vision	Yes ☐ No ☐
Cataracts	Yes ☐ No ☐	Lazy Eye	Yes ☐ No ☐	Double Vision	Yes ☐ No ☐
Macular Degeneration	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐	Floaters	Yes ☐ No ☐
Eye Injury	Yes ☐ No ☐	Dry Eyes	Yes ☐ No ☐	Tearing	Yes ☐ No ☐
Retinal Disease	Yes ☐ No ☐	Eyelid Problem	Yes ☐ No ☐	Eye Discharge	Yes ☐ No ☐
Blindness	Yes ☐ No ☐				

Do you wear glasses? Yes ☐ No
Do you wear contacts? Yes ☐ No ☐ If yes, what kind? _____
Have you had Lasik? Yes ☐ No

OCULAR SURGICAL HISTORY

Please list **ALL** previous eye surgeries: _____

_____

FAMILY EYE HISTORY

Does any family member have eye disease? Yes ☐ No ☐ If yes, explain: _____

_____

SOCIAL HISTORY

Do you drink alcohol? Yes ☐ No ☐ Social ☐

Do you currently use tobacco products? Yes ☐ No ☐
Do you have a history of tobacco use? Yes ☐ No ☐

MEDICAL HISTORY

Type 1 Diabetes	Yes ☐ No ☐	Ulcers/Digestive	Yes ☐ No ☐	Allergies	Yes ☐ No ☐
Type 2 Diabetes	Yes ☐ No ☐	Kidney Disease	Yes ☐ No ☐	Arthritis	Yes ☐ No ☐
Hypertension (High BP)	Yes ☐ No ☐	Neurological	Yes ☐ No ☐	Headaches	Yes ☐ No ☐
Heart Disease	Yes ☐ No ☐	Psychiatric	Yes ☐ No ☐	HIV/AIDS	Yes ☐ No ☐
History of Stroke	Yes ☐ No ☐	Cancer	Yes ☐ No ☐	Hepatitis C	Yes ☐ No ☐
Ear/Nose Throat	Yes ☐ No ☐	Thyroid	Yes ☐ No ☐	Autoimmune	Yes ☐ No ☐
Lung Disease	Yes ☐ No ☐	Are you pregnant?	Yes ☐ No ☐		

MEDICATIONS

Please list names of ALL medications that you are currently taking: _____

_____

Please list names of **ALL** medications that you are allergic to: _____

_____

Signature _____ Date _____/_____/_____