MEDICAL HISTORY

NAME _____ DATE _____

DRUG ALLERGIES _____

List **ALL MEDICATIONS/VITAMINS** you are taking: _____

_____

Circle Yes or No

YES	NO	Fever	YES	NO	Chronic Bronchitis
YES	NO	Fatigue	YES	NO	Diabetes _____
YES	NO	Weight loss or gain	YES	NO	Ulcers
YES	NO	(Women) Currently Pregnant	YES	NO	Kidney Disorder
YES	NO	Sinus Infections	YES	NO	Bladder Disorder
YES	NO	Cough	YES	NO	Muscle Pain
YES	NO	Heart Disease	YES	NO	Arthritis/Joint Pain
YES	NO	High Blood Pressure	YES	NO	Seizures
YES	NO	Irregular Heart Beat	YES	NO	Multiple Sclerosis
YES	NO	Heart Attack	YES	NO	Psychiatric Disorder _____
YES	NO	Pacemaker	YES	NO	Blood Disorder _____
YES	NO	Emphysema	YES	NO	Cancer _____
YES	NO	Asthma	YES	NO	Seasonal Allergies
			YES	NO	Food Allergies

YOUR OCULAR HISTORY (Have you been diagnosed with any of the following in the past?)

DATE OF LAST EYE EXAMINATION _____

YES	NO	Cataracts – Right/Left	YES	NO	Retinal Detachment – Right/Left
YES	NO	Glaucoma – Right/Left	YES	NO	Diabetic Retinopathy – Right/Left
YES	NO	Macular Degeneration	YES	NO	Amblyopia – Right/Left
YES	NO	Strabismus – Right/Left	YES	NO	Dry Eyes
YES	NO	Other _____	YES	NO	Keratoconus

OCULAR SURGERIES

YES	NO	Cataracts – Right/Left	YES	NO	Lasik – Right/Left
YES	NO	Glaucoma – Right/Left	YES	NO	Corneal Transplant – Right/Left
YES	NO	RK – Right/Left	YES	NO	YAG Laser – Right/Left
YES	NO	PRK – Right/Left	YES	NO	Laser Diabetes – Right/Left
YES	NO	Strabismus – Right/Left	YES	NO	Other _____

HOSPITALIZATION HISTORY (Primary Diagnosis and Date)

_____

SOCIAL HISTORY

YES	NO	Trouble Driving	YES	NO	Alcohol
YES	NO	Tobacco	YES	NO	Drugs

Do you wear Glasses YES NO Contacts YES NO How Long? _____

Do you have any Occupational problems?_____

FAMILY HISTORY (Has any blood relative had any of the following? Please list relationship to patient.)

YES	NO	Blindness _____	YES	NO	Glaucoma _____
			YES	NO	Diabetes _____
YES	NO	Macular Degeneration _____	YES	NO	Stroke _____
			YES	NO	Cancer _____
YES	NO	High Blood Pressure _____	YES	NO	Arthritis _____
YES	NO	Lazy Eye _____	YES	NO	Other _____