NAME_____ DATE_____

Date of birth _____

Who referred you to the office? _____

Who is your primary Doctor? _____

OCULAR HISTORY:

Cataract Surgery ***YES*** ***NO*** When? _____
Glaucoma ***YES*** ***NO*** How long? _____
Macular Degeneration ***YES*** ***NO*** How long? _____
Retinal Detachment ***YES*** ***NO*** When? _____
Other_____

Has anyone in your family (blood relatives) had any eye problems:

Cataracts ***YES*** ***NO***
Glaucoma ***YES*** ***NO***
Macular Degeneration ***YES*** ***NO***
Blindness ***YES*** ***NO***
Retinal Detachment ***YES*** ***NO***
Other_____

Medical history:
Have **you** ever been told you have:

Diabetes ***YES*** ***NO*** Type 1 or 2 How long? _____
Hypertension ***YES*** ***NO*** How long? _____
Heart problems ***YES*** ***NO*** When? _____
High Cholesterol ***YES*** ***NO*** When? _____
Bleeding disorders ***YES*** ***NO***
Aids or HIV ***YES*** ***NO***

Has anyone in your family (blood relatives) had any Of these conditions:
Diabetes ***YES*** ***NO***
Hypertension ***YES*** ***NO***

Please list all medications including any eye medications that your are currently taking:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Major medical conditions:
Cancer _____
Heart attack _____
Thyroid problems _____
Breathing or lung problems
_____
Other _____
_____
_____

Allergic to medications
Iodine ***YES*** ***NO***
Penicillin ***YES*** ***NO***
Sulfa ***YES*** ***NO***
Others _____
_____
_____

Social history:
Do you smoke? ***YES*** ***NO***
Drink alcohol? ***YES*** ***NO***

Occupation _____

CONTINUE>>>>

ARE YOU CURRENTLY BEING TREATED OR PREVIOUSLY DIAGNOSED WITH ANY OF THE FOLLOWING?

CANCER YES NO
Breast..... ___ / ___
Lung..... ___ / ___
Prostate..... ___ / ___
Pancreatic..... ___ / ___
Other _____
_____

MUSCULO—SKELETAL YES NO
Rheumatoid arthritis..... ___ / ___
Lupus..... ___ / ___
Other_____
_____
_____
_____

NEUROLOGICAL YES NO
Dizziness..... ___ / ___
Migraines..... ___ / ___
Other_____

ENDOCRINE YES NO
Diabetes..... ___ / ___
Thyroid..... ___ / ___
Other_____

RESPIRATORY YES NO
Asthma..... ___ / ___
Emphysema..... ___ / ___
Other _____

HEMATOLOGICAL/LYMPHATIC YES NO
Anemia..... ___ / ___
Bleeding disorder..... ___ / ___
Other_____

CARDIOVASCULAR YES NO
Congestive heart failure..... ___ / ___
Heart attacks..... ___ / ___
Irregular—fast heartbeat..... ___ / ___
High Blood pressure..... ___ / ___
Other _____

PSYCHIATRIC YES NO
Depression..... ___ / ___
Schizophrenia..... ___ / ___
Other _____

GASTROINTESTINAL YES NO
Jaundice—hepatitis..... ___ / ___
Other _____
_____

GENITOURINARY YES NO
Kidney disease..... ___ / ___
Other _____
_____

ENT YES NO
Sinus congestion ..... ___ / ___
Dry throat - mouth..... ___ / ___