MEDICAL HISTORY

NAME: _____ DATE _____

ALLERGIES

_____

List ALL MEDICATIONS/VITAMINS you are taking:

_____

_____

_____

Circle yes or no

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

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

DATE OF LAST EXAM: _____

Do you wear glasses? YES NO Contacts? YES NO If yes, type _____ How long _____

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 Eye
YES	NO	Other _____	YES	NO	Keratoconus

OCULAR SURGURIES

YES	NO	Cataracts- Right/Left	YES	NO	Strabismus- 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	Lasik- Right/Left	YES	NO	Laser Diabetes- Right/Left
YES	NO	PRK- Right/Left	YES	NO	Other

_____

HOSPITALIZATION HISTORY Date and Diagnosis

_____

FAMILY HISTORY

YES	NO	Blindness_____	YES	NO	Glaucoma _____
YES	NO	Cataracts _____	YES	NO	Diabetes _____
YES	NO	Macular Degeneration_____	YES	NO	Amblyopia _____
YES	NO	Retinal Detachment _____	YES	NO	Stroke _____
YES	NO	High Blood Pressure _____	YES	NO	Keratoconus _____
YES	NO	Arthritis _____	YES	NO	Other _____

SOCIAL HISTORY

YES	NO	Tobacco If yes, how often _____	YES	NO	Alcohol If yes, how often _____
YES	NO	Drugs If yes, what and how often _____			
YES	NO	Do you have any trouble driving?			