Patient Name: _____ **Date:** ____/____/____ **DOB:** ____/____/____

Eye Medical History	Self	Family
Cataracts	Yes / No	Yes / No
Corneal Problems	Yes / No	Yes / No
Diabetic Changes	Yes / No	Yes / No
Eye Injury	Yes / No	Yes / No
Eyelid Problems	Yes / No	Yes / No
Eye Muscle Problems	Yes / No	Yes / No
Glaucoma	Yes / No	Yes / No
Lazy Eye	Yes / No	Yes / No
Macular Degeneration	Yes / No	Yes / No
Retinal Problems	Yes / No	Yes / No
Eye Surgeries:		

History of Medical Conditions (circle all that apply)		Self
Arthritis:	Fibromyalgia, Lupus, Osteoarthritis, Rheumatoid Arthritis	Yes / No
Cancer:	Breast, Colon, Liver, Lung, Prostate, Skin, other:	Yes / No
Cardiovascular:	Arrhythmia, Atria Fibrillation, Bypass, Congestive Heart Failure, Murmer	Yes / No
	Heart Attack, High Blood Pressure, High Cholesterol, High Lipids, Stent	
Diabetes	Type I, Type II, Number of Years: Blood Sugar HgB A1C:	Yes / No
GI:	Crohn's, Colitis, Gastroesophageal Reflux, Pancreatitis, Ulcers	Yes / No
Hematological:	Anemia, Bleeding Problems, Leukemia	Yes / No
Infections:	AIDS, Herpes, HIV, Hepatitis A/B/C	Yes / No
Neurologic:	Alzheimer's, Epilepsy, Migraines, MS, Stroke, TIA's	Yes / No
Psychiatric:	Anxiety, Bipolar, Depression, Panic Disorder	Yes / No
Pulmonary:	Asthma, COPD, Sarcoidosis, Tuberculosis	Yes / No
Thyroid:	Graves Disease, Hyperthyroid, Hypothyroid, Radioactive Iodine	Yes / No
Pregnant:	Yes / No **Nursing:** Yes / No	
Other:		
Surgical Procedures:		

Social History
Do you drive: Y / N
Do you drink alcohol: Y / N, Rarely / Occasionally / Daily / Socially
Do you smoke: Y / N, Previous Smoker: Y / N, How many packs per day:

Drug Allergies:

Medications:		