



List any medications & dosages you currently take (prescription and over-the-counter):

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Do you have any allergies?  YES  NO

If YES, list: \_\_\_\_\_

Do you currently have any problems in the following areas? If "YES", please provide information:

	YES	NO	Explanation of Problem
<b>ALLERGIC/IMMUNOLOGIC</b> (Hay fever, lupus, Sjögrens, etc.)			
<b>CARDIOVASCULAR</b> (Heart, blood pressure, stroke)			
<b>GENERAL/CONSTITUTIONAL</b> (Fever, weight loss, other)			
<b>EARS, NOSE, THROAT</b> (Sinus, ear infection, chronic cough, dry mouth, etc.)			
<b>ENDOCRINE</b> (Diabetes, thyroid, etc.)			
<b>EYES</b> (glaucoma, cataract, retinal disease, etc.)			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
<b>GASTROINTESTINAL</b> (Stomach ulcers, intestinal disease, etc)			
<b>GENITAL, KIDNEY, BLADDER</b>			
<b>BLOOD/LYMPH</b> (Cancer, high cholesterol, anemia)			
<b>SKIN</b> (Dermatitis, skin cancer, etc.)			
<b>MUSCLES, BONES JOINTS</b> (Arthritis, etc)			
<b>NEUROLOGICAL</b> (Multiple sclerosis, headaches)			
<b>PSYCHIATRIC</b> (Anxiety, depression, insomnia)			
<b>RESPIRATORY</b> (Asthma, emphysema, bronchitis)			

Please circle if you have had the following: arthritis, cataracts, eye condition, glaucoma, hypertension, shortness of breath, sinus, thyroid disorders, ulcer, chicken pox, hernia, measles, polio, venereal disease, hemorrhoids, liver disease, mumps, rheumatic fever, hepatitis, malaria or pancreatitis.

List any other past medical problems: \_\_\_\_\_

List any past surgeries: (tonsillectomy, appendectomy): \_\_\_\_\_

List any past Ocular surgeries: (Cataract, Lasik, PRK, etc) \_\_\_\_\_

**FAMILY HISTORY** M=mother F=father S=sibling GF=grandfather GM=grandmother

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Retinal detachment			
Other			

**SOCIAL HISTORY**

Do you drink Alcohol?  YES  NO If YES: occasional 1 /day 2-3 /day 4+/day  
 Have you ever had a blood transfusion?  YES  NO  
 Have you ever tried to wear contact lenses?  YES  NO  
 Do you currently wear contact lenses?  YES  NO If YES, how long? \_\_\_\_\_  
 Do you drive?  YES  NO  
 Do you have visual difficulty when driving?  YES  NO  
 Do you have problems with night vision?  YES  NO

Employment Status: Full-time, Part-time, Homemaker, Self-employed, Retired, Disabled, Unemployed

Do you currently wear glasses?  YES  NO If YES, how long in current prescription? \_\_\_\_\_

Do you use illegal drugs?  YES  NO

Marital Status (married, divorced, single, widowed):

Do you smoke?  YES  NO If YES: occasional 1 pack/day 2-3 pack/day 4+ packs/day

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_