Patient Name: _____ Date: _____
Primary Care Physician: _____
Briefly state the kind of eye problem you are having: _____
_____

Do you wear glasses? YES NO Do you wear Contact Lenses? YES NO Are you pregnant? YES NO

MEDICAL HISTORY

Do you now have or have you ever had:

Diabetes	YES NO	Concussion	YES NO	Dermatitis	YES NO
High Cholesterol	YES NO	Stroke	YES NO	Rosacea	YES NO
High Blood Pressure	YES NO	Muscle Disease	YES NO	Bleeding Disorder	YES NO
Heart Attack	YES NO	Arthritis	YES NO	Migraine	YES NO
Thyroid Problems	YES NO	Hepatitis	YES NO	Allergies	YES NO
Cancer	YES NO	AIDS or HIV positive	YES NO	Sinusitis	YES NO
Emphysema	YES NO	Shingles or Herpes	YES NO	Asthma	YES NO
				Other _____	

SURGICAL HISTORY

Bypass	YES NO	Hysterectomy	YES NO	Cosmetic Surgery	YES NO
Pacemaker	YES NO	Mastectomy	YES NO	Appendectomy	YES NO
Carotid Artery	YES NO	Prostate	YES NO	Joint Replacement	YES NO
Tumor	YES NO	Colon Surgery	YES NO	Other_____	YES NO
Brain Surgery	YES NO	Gallbladder	YES NO		

EYE HISTORY

Retinal Detachment	YES NO	Retinal Surgery	YES NO	Corneal Transplant	YES NO
Glaucoma	YES NO	Glaucoma Surgery	YES NO	Dry Eye	YES NO
Cataract	YES NO	Cataract Surgery	YES NO	Double Vision	YES NO
Macular Degeneration	YES NO	Laser Surgery	YES NO	Iritis/ Uveitis	YES NO
Diabetic Retinopathy	YES NO	Eyelid Surgery	YES NO	Floaters/ Flashing lights	YES NO
Crossed Eyes	YES NO	Strabismus Surgery	YES NO	Eye Injury_____	YES NO
Lazy Eye	YES NO	Refractive Surgery	YES NO	Other_____	

FAMILY HISTORY

Have any family members ever had:

Cataracts	YES NO	Blindness	YES NO	High blood pressure	YES NO
Glaucoma	YES NO	Cancer	YES NO	Heart Disease	YES NO
Retinal Disease	YES NO	Diabetes	YES NO	Other_____	YES NO

SOCIAL HISTORY

Do you now use:

Alcohol	YES NO	Tobacco	YES NO	Social Drugs	YES NO

PLEASE LIST CURRENT MEDICATIONS:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

DRUG ALLERGIES:

_____
_____
_____
_____
_____

_____
_____

FOR OFFICE USE ONLY

Updated visit: initials:

_____ _____
_____ _____