

NAME _____ DATE _____

Do you currently wear:	Glasses contacts Interested in contacts (please circle)	RACE: White Native American Black/African American Hispanic Asian Multi-racial Decline to answer Other _____
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PAST SURGICAL PROCEDURES: _____

Please circle any of the following that apply to your eye history:

Blepharitis Corneal transplant Cataract Cataract Surgery Glaucoma Diabetic Retinopathy Eye Injury
 Muscle Disorders Tear Duct Problems Macular Degeneration Iritis Retinal Detachment LASIK / PRK / RK

Do you currently have any problems in the following areas? (if yes please circle or list if not listed)

Allergic/Immunologic (Environmental/food allergies)	<input type="checkbox"/> yes <input type="checkbox"/> no	
General/Constitutional (Fever, Weight Loss, ect.)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Ears ,Nose, Throat (Sinus ,ear ache, hearing loss, dry mouth)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Cardiovascular (High BP, racing pulse, heart attack Pacemaker)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Constitutional (fatigue, fever and night sweats)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Gastrointestinal (stomach ulcers, constipation, diarrhea)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Muscles, Bones, Joints (arthritis, joint pain, stiffness, swelling, Rheumatoid disease)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Skin (skin disorders, rash, growths)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Neurological (numbness, dizziness, headaches, stroke)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Psychiatric (anxiety, depression, insomnia, ect.)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Endocrine (Diabetes, Hypothyroid, Hyperthyroid, ect.)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Genital, Kidney, Bladder (prostate disease)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Respiratory (asthma, COPD, SOB, Emphysema)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Blood/Lymph (high Cholesterol, anemia, ect.)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Pregnant or Nursing	<input type="checkbox"/> yes <input type="checkbox"/> no	

List your prescribed drugs and over-the-counter drugs			Medication Allergies	Reaction
Name the Drug	Dosage	Frequency		
			Immediate Family Members have any of the following: circle	
			Diabetes	Blindness
			Glaucoma	Macular Degeneration
			Muscle Disorders of the Eye	Retinal Detachment
				High BP

Social History : Alcohol none/rarely/occasional **Tobacco :** Chew/Smoke: Yes or NO How Much _____