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_______________

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