Patient Name:_____ DOB:_____

MEDICAL HISTORY

Please circle Yes or No if you have been diagnosed with the following:

	Circle		Year Diagnosed
High Cholesterol	YES	NO	
High Blood Pressure	YES	NO	
Heart Valve Disease	YES	NO	
Coronary Artery Disease	YES	NO	
Asthma	YES	NO	
COPD	YES	NO	
Inflammatory Disease	YES	NO	Type:
Arthritis	YES	NO	Rheumatoid: Y / N
Headaches	YES	NO	
Migraines	YES	NO	
Sleep Apnea	YES	NO	C-Pap: Y / N
Irregular heartbeat	YES	NO	
Heart Attack	YES	NO	
Stroke	YES	NO	
Multiple Sclerosis	YES	NO	
Cancer	YES	NO	Type:
Hepatitis	YES	NO	Type:
HIV/AIDS	YES	NO	
Lupus	YES	NO	
Thyroid Disease	YES	NO	Circle: Hyper or Hypo
Diabetes	YES	NO	Type:
Dementia	YES	NO	
Alzheimer's	YES	NO	
GERD/Acid Reflux	YES	NO	
GOUT	YES	NO	
Parkinson's Disease	YES	NO	
Sarcoidosis	YES	NO	
Enlarged Prostate	YES	NO	
Bell's Palsy	YES	NO	
Pregnant and/or Nursing	YES	NO	
Herpes Simplex (Cold Sores)	YES	NO	
Herpes Zoster (Shingles)	YES	NO	
Osteoporosis	YES	NO	
Seizures	YES	NO	
Dizziness/Vertigo	YES	NO	

Pseudotumor Cerebri	YES	NO	
Autism	YES	NO	
Seasonal allergies	YES	NO	
Sjogren's Disease	YES	NO	
Alcohol Addiction	YES	NO	
Drug Addiction	YES	NO	
Depression	YES	NO	
Anxiety	YES	NO	

FAMILY MEDICAL HISTORY

	Circle		Who? (Excluding self)
Diabetes	YES	NO	
Heart Disease	YES	NO	
Hypertension	YES	NO	
Stroke	YES	NO	
Cancer	YES	NO	
Rheumatoid Arthritis	YES	NO	
Thyroid Disease	YES	NO	
Lupus	YES	NO	
Blindness	YES	NO	
Crossed/Lazy Eye	YES	NO	
Glaucoma	YES	NO	
Cataracts	YES	NO	
Macular Degeneration	YES	NO	
Corneal Disease	YES	NO	
Corneal Transplant	YES	NO	
Retinal Detachment	YES	NO	

Please list any surgeries or other pertinent medical information:

Patient Name:_____ DOB:_____

EYE HEALTH

☐ Contacts ☐ Glasses

If yes, Contact Lens Brand_____

☐ Frequent Infections	☐ Blurry Vision	☐ Keratoconus
☐ Droopy Eyelids	☐ Dryness/Burning	☐ Ocular migraines
☐ Eyelid Matting	☐ Itching	☐ Previous ocular surgery
☐ Glare	☐ Crossed/Lazy Eye	Please list:
☐ Sudden loss of vision	☐ Cataracts	_____
☐ Loss of central vision	☐ Glaucoma	_____
☐ Loss of peripheral vision	☐ Corneal Disease	_____
☐ Double Vision	☐ Retinal Disease	_____
☐ Floaters/Flashes of Light	☐ Macular Degeneration	_____
☐ Eye Allergies	☐ Optic Neuritis	_____
☐ Iritis/Uveitis	☐ Retinopathy	

SOCIAL HISTORY

Tobacco Use: (Please circle)

Never Smoker Former Smoker Chewing Tobacco E-Cigarettes

Current Ever Day Smoker Current Some Day Smoker

Packs per day: _____

Alcohol Use: (Please circle)

None Occasional/Social 1-2 Drinks/Day 3-4 Drinks/Day

Substance Abuse: (Please circle)

Yes No Formerly

Substances Used: _____

MEDICATION RECORDS

Pharmacy: _____ Phone:_____

Address: _____

Medication/Dosage and/or Over the Counter Vitamins/Herbal Supplements and any Eye drops				
Name	Strength	Dose	How Often	Medical Condition
EXAMPLE: Lisinopril	40mg	1 tablet	1 x day	Blood Pressure

DRUG ALLERGIES & REACTIONS

Do you have any allergies to medication? YES NO

If so, please list and describe reaction: