Name_____ DOB: _____

Have you ever had an eye surgery or an eye injury? □ Yes □ No If yes, please describe:_____
List all non-eye related surgeries or conditions:_____

Medications and Allergies

Do you take any medications? □ Yes □ No If YES, please list:_____
_____
Do you use any EYE medications? □ Yes_____ □ No_____
Do you have any drug allergies? □ Yes _____□ No_____

Personal History (conditions you have)

Do you currently have any of the following problems:	**YES**	**NO**	**Details**
Chronic fever, unexplained weight loss/gain, fatigue)	□	□	
Endocrine (Hormonal Dysfunction, Thyroid Dysfunction Diabetes)	□	□	Last A1C_____Date_____
Ear/nose throat problems (hearing loss, sinus issues, vertigo)	□	□	
Allergic Immunologic (Environmental Allergy, Lupus, Rheumatoid Arthritis)	□	□	
Heart problems (chest pain, irregular heart beat)	□	□	
Hematologic Lymphatic (Leukemia, Anemia, Cancer Large Vol Blood Loss)	□	□	
Respiratory problems (shortness of breath, coughing, wheezing)	□	□	
Gastrointestinal problems (heartburn, abdominal pain, and crohns)	□	□	
Musculoskeletal problems (muscle aches, joint pain, swollen joints)	□	□	
Skin problems (rashes, excessive dryness)	□	□	
Neurological problems (numbness, weakness, headaches, paralysis)	□	□	
Psychiatric problems (depression, anxiety)	□	□	
Circulatory problems (high blood pressure, stroke)	□	□	

Do you smoke? □ Yes □ No □ Past □ Never Do you drink alcohol? □ Yes □ No □Past □ Never

Family History (conditions in your blood relatives)

SYSTEMIC CONDITIONS

□ arthritis □ high blood pressure
□ diabetes □ high cholesterol
□ cancer □ stroke
□ heart disease □ thyroid disease
OTHER:_____

EYE CONDITIONS

□ blindness □ "lazy eye"
□ cataracts □ macular degeneration
□ color blindness □ night blindness
□ glaucoma □ retinal
OTHER"_____