PERSONAL MEDICAL HISTORY

MAIN REASON FOR VISIT:

Medications (including eye drops, birth control pills, vitamins and over-the-counter medications):

For:	For:
For:	For:
For:	For:
For:	For:

Allergies: ☐ Yes ☐ No ☐ No known medication allergiesPlease list: _____

Have you ever had general surgery? ☐ Yes ☐ No Please List: _____

Have you ever had eye surgery? ☐ Yes ☐ No Please List: _____

Do you wear contacts? ☐ Yes ☐ No Type: _____ Are you interested in contacts? ☐Yes ☐No LASIK? ☐Yes ☐NO

Smoking Status: ☐ Current Every Day ☐ Current Some Day☐ Former☐ Never

Alcohol Use? ☐ None ☐Social ☐Moderate ☐Excessive **Narcotic/Drug Use?** ☐None ☐Social ☐Dependence

Are you currently pregnant or nursing? ☐ Yes ☐No

☐ No ☐Yes **General** (Cancer, Developmental Disability, Trauma, Loss of Blood) Other: _____

☐ No ☐Yes **Ears/Nose/Mouth/Throat** (Hearing Loss, Sinus) Other: _____

☐ No ☐Yes **Cardiovascular** (High Cholesterol, High Blood Pressure, Stroke, Heart Disease) Other: _____

☐ No ☐Yes **Respiratory** (Asthma, Bronchitis, Emphysema, COPD) Other: _____

☐ No ☐Yes **Gastrointestinal** (Chron's, Colitis, Acid Reflux, Colon Cancer) Other: _____

☐ No ☐Yes **Genitourinary** (bladder cancer, prostate cancer) Other _____

☐ No ☐Yes **Musculoskeletal** (Osteoarthritis, Fibromyalgia, Muscular Dystrophy, Ankylosing Spondylitis) Other: _____

☐ No ☐Yes **Skin** (Eczema, Rosacea, Psoriasis, Acne) Other: _____

☐ No ☐Yes **Neurological** (Multiple Sclerosis, Epilepsy, Cerebral Palsy, Tumor) Other: _____

☐ No ☐Yes **Psychiatric** (ADHD, Depression, Anxiety, Schizophrenia) Other: _____

☐ No ☐Yes **Endocrine** (Diabetes, Thyroid Disorder, Hormonal Dysfunction) Other: _____

☐ No ☐Yes **Lymphatic/Hematological** (Anemia, Leukemia, Bleeding Disorder) Other: _____

☐ No ☐Yes **Allergic/Immunologic** (Seasonal, HIV/AIDS, Rheumatoid Arthritis, Lupus, Neurofibromatosis) Other: _____

☐ No ☐Yes **Eyes** (Injuries, Surgeries, Glaucoma, Macular Degeneration, Cataracts, Lazy Eye) Other: _____

☐ No ☐Yes **Other** _____

PERSONAL EYE HISTORY

Are you currently or have you ever experienced any of the following problems?

☐ Blurred Vision	☐ Double Vision	☐ Eye Strain	☐ Eye Pain	☐ Burning Eyes
☐ Itching Eyes	☐ Dry Eyes	☐Red Eyes	☐ Watery Eyes	☐ Light Sensitivity
☐ Floaters	☐Flashes	☐ Headaches/Migraines	☐ Loss of Vision	☐ Crossed Eyes
☐ Poor Night Vision	☐ Poor Color Vision	☐ Droopy Eyelid	☐ Other:_____	

FAMILY HISTORY

*Please indicate **WHO** in your family (parents, grandparents, siblings, children) has been diagnosed with the following:*

☐ Cataract _____	☐ Macular Degeneration _____	☐ Diabetes _____
☐ Glaucoma _____	☐ Lazy/Crossed Eye _____	☐ High Blood Pressure _____
☐ Blindness _____	☐ Retinal Detachment _____	☐ High Cholesterol _____
☐ Cancer _____	☐ Thyroid Disease _____	☐ Other: _____