Patient's Name: _____ **Date:** _____

MEDICAL INFORMATION (PLEASE CHECK ALL THAT APPLY)

DO YOU CURRENTLY:

WEAR GLASSES **YES** **NO** IF YES, WHAT ARE THE AGE OF YOUR CURRENT GLASSES _____

WEAR CONTACT LENSES **YES** **NO** IF YES, WHAT BRAND OF CONTACTS _____

HAVE YOU HAD:

CATARACT SURGERY **YES** **NO** EYE MUSCLE SURGERY **YES** **NO** LASIK/PRK SURGERY **YES** **NO**
RETINAL SURGERY **YES** **NO** TRAUMATIC EYE INJURY **YES** **NO**

VISION HISTORY

Do you or anyone in your immediate family have:

			RELATION
Amblyopia/Lazy Eye	YES	NO	_____
Blindness	YES	NO	_____
Cataracts	YES	NO	_____
Crossed/Turned Eyes	YES	NO	_____
Diabetic Retinopathy	YES	NO	_____
Double Vision	YES	NO	_____
Flashes/Floaters	YES	NO	_____
Glaucoma	YES	NO	_____
Macular Degeneration	YES	NO	_____
Retinal Detachment	YES	NO	_____
Other _____	YES	NO	_____

SOCIAL HISTORY

DO YOU SMOKE NO YES, _____ PACK PER DAY
ALCOHOL USE NO YES, _____ DRINKS PER WEEK

FEMALES: ARE YOU

PREGNANT: NO YES, _____ WEEKS NURSING: YES NO

ALLERGENS:

Animal Dander **YES** **NO**
Environmental **YES** **NO**

DRUG ALLERGIES: NO YES. list below

LIST ALL CURRENT MEDICATIONS

YOUR CURRENT MEDICAL HISTORY: Circle all that apply.

CARDIOVASCULAR		
Elevated Cholesterol	YES	NO
Heart Disease	YES	NO
High Blood Pressure	YES	NO
CONSTITUTION		
Weight Gain/Loss	YES	NO
EAR, NOSE, THROAT		
Sinuses	YES	NO
ENDOCRINE		
Diabetes	YES	NO
Thyroid Disorder	YES	NO
GASTRONITESTINAL		
Acid-Reflux	YES	NO
Crohn's Disease	YES	NO
Hepatitis	YES	NO
GENITOURINARY		
Kidney Stones	YES	NO
Genitals/Kidney/Bladder	YES	NO
Sexually Trans. Disease	YES	NO
HEMATOLOGIC/LYMPHATIC		
Anemia	YES	NO
Leukemia	YES	NO
Sickle Cell Trait/Disease	YES	NO
OTHER:		
History of Cancer	YES	NO

IMMUNOLOGIC		
Herpes Simplex/Zoster	YES	NO
HIV Positive	YES	NO
Sarcoidosis	YES	NO
INTEGUMENTARY		
Rosacea	YES	NO
Lupus	YES	NO
MUSCULOSKELETAL		
Rheumatoid Arthritis	YES	NO
Osteoporosis	YES	NO
NEUROLOGICAL		
Headache	YES	NO
Migraines	YES	NO
Seizures	YES	NO
PSYCHIATRIC		
ADD	YES	NO
Anxiety Disorder	YES	NO
Depression/Bipolar	YES	NO
RESPIRATORY		
Asthma	YES	NO
COPD	YES	NO
Sleep Apnea	YES	NO

OTHER: _____