Medical History

Name: ______________________________________ Birthdate: _______________ Date: _______________

Address: ____ City: ______________________ State: ________

Phone: ______________ Work: __________________ Cell: _______________ Email: ______________________

Occupation: ___________________________________ Employer: _____________________________________

Last Eye exam: ________________________ Do you wear glasses? ___________ Contacts? _______________

If yes, what kind of contacts (type, brand)? ____

Please list any major surgeries you have had: ____

Do you smoke? YES/NO Have you ever? YES/NO If yes, when? For how long? _______________________

Do you Drink? YES/NO How much? ______________________

Do you currently, or have you ever had, any problems in the following areas? (Please circle any that apply)

Constitutional: Cancer, fatigue, developmental disabilities

ENT: Hearing loss, sinusitis, laryngitis, dry mouth

Neurological: MS, Cerebral palsy, epilepsy, tumor, stroke, migraines

Psych: Depression, anxiety, attention defecit, bipolar

Cardiovascular: Stroke, hypertension, heart disease, vascular disease, congestive heart failure

Respiratory: Asthma, chronic bronchitis, emphysema

Gastrointestinal: Chrohn's, colitis, ulcer, acid reflux, celiac disease

Genitourinary: kidney disease, prostate, STD, pregnant, nursing

Muscle/Skeletal: Arthritis, osteoarthritis, fibromyalgia, muscular dystrophy, ankylosing spondylitis, osteoporosis, gout

Integumentary: Eczema, rosacea, psoriasis, herpes simplex, herpes zoster

Endocrine: Diabetes, thyroid dysfunction, hormonal dysfunction

Lymphatic: Anemia, blood loss, ulcer, high cholesterol

Allergy/Immune: Drug allergies, environmental allergies, Rheumatoid arthritis, Lupus, Sjogren's Symdrome

If yes to allergies, what are you allergic to? ____

Other: ____

Please list any medications (including dosage and frequency): ____________________________________

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Do you have (or have had) any of the following? (Please circle any that apply)

Glaucoma, Cataract, Macular degeneration, Patching, Inflammatory disorder, Strabismus, Amblyopia,

Keratoconus, Dry Eye, Nystagmus, Retinal degeneration/Hole/Detachment

Any eye injuries? ______ If yes, please list: ____

Any eye surgeries? _____ If yes, please list: ____

Family History

Please mark yes or no and list family member/s affected:

Disease/Condition	No	Yes	Relation
Blindness	___	___	____
Cataracts	___	___	____
Glaucoma	___	___	____
Macular Degen	___	___	____
Retinal Detach	___	___	____
Cancer	___	___	____
Diabetes	___	___	____
Hypertension	___	___	____
Kidney Disease	___	___	____
Lupus	___	___	____
Thyroid Disease	___	___	____

Other (please list): ____