Name: ____________________ Birth Date: ____________________

Primary Care Doctor: ____________________ Specialty Doctor: ____________________

MEDICAL HISTORY (Circle all that apply)

Diabetes (date) ________	Stroke
High Blood Pressure	Asthma / COPD
Atrial Fibrillation	TB
Depression	Cancer
Kidney Disease	HIV/AIDS
Rheumatoid Arthritis	Arthritis
Pacemaker / Defibrillator	(date) ________
MRSA (date) ________	Sleep Apnea

Past Surgical Procedures / Dates

Other Medical Conditions:

Current Immunizations (please ciricle)**:** Influenza Y N Pneumonia Y N

Prescription Medications/vitamins:
(with dosage)

Eye Medication/drops :
(Please indcate eye and times per day)

Allergies/Reaction:

Eye Procedures/Injuries and dates

Cataract	R/L	Date:
Glaucoma	R/L	Date:
Lasik/PRK/RK	R/L	Date:

Other Procedures/Injuries:

Family History:

Corneal Transplant	Cancer
Macular Degeneration	Glaucoma
Congenital Defects	Diabetes
Retinal Detachment	
Loss of vision at a young age	

Eye Conditions (Circle all that apply)

Retinal Detachment	Glaucoma
Diabetic Retinopathy	Cataract
Corneal Transplant	Iritis/Uveitis
Macular Degeneration	

PERSONAL/SOCIAL

Marital Status: S M W D Driving: Y N Occupation:__________

Smoking History: Y / N # Packs/Day? ____ Years?: ____ Quit?: Y N Year?:_______

Alcohol Use: None Rare/Occasional Weekly Daily

Recreational Drugs: Y N Past Type:______________________

12/19/2018

Please complete other side

REVIEW OF SYSTEMS

(please circle all that apply):

GENERAL: NONE / fever / weight loss / no appetite / fatigue / very thirsty
Other: ______________________________

EYES: NONE / blurring / tearing / burning / itching / pain
Other: ______________________________

EARS/ NOSE/THROAT: NONE / poor hearing / sinus problems
Other: ______________________________

HEART: NONE / high/low blood pressure / slow beat / irregular beat / heart failure
Other: ______________________________

LUNGS: NONE / asthma / emphysema / bronchitis
Other: ______________________________

ABDOMINAL: NONE / diarrhea / constipation / ulcer / GI bleeding
Other: ______________________________

GENITAL/URINARY: NONE / kidney stones / infection / impotence / frequent urination
Other: ______________________________

SKIN/JOINTS: NONE / rashes / breast lumps / cold hands & feet / easy bruising / arthritis
Other: ______________________________

NEUROLOGICAL: NONE / migraines / headaches / stroke / Alzheimer's
Other: ______________________________

BLOOD: NONE / anemia / prior transfusion / HIV virus / easy bruising
Other: ______________________________

Psychiatric: NONE / depression / bipolar / anxiety / poor memory
Other: ______________________________

ENDOCRINE: NONE / low thyroid / high thyroid / insulin diabetes / non-insulin diabetes
Other: ______________________________