NAME: ______________________________ **DATE:** ______________

OCCUPATION: ______________________________

FAMILY DOCTOR: ______________________________

MEDICAL HISTORY:
(Please circle the following health conditions you have been treated for)

Diabetes	High Blood Pressure	Stroke
Heart Trouble	Arthritis/Joint Pain	Thyroid Problems
Tuberculosis	Kidney Problems	Skin Disorders
Cancer	HIV/Blood Disorders	Asthma/Breathing Problems

Please list any other problems not listed above:

____

FAMILY MEDICAL HISTORY:
(Please circle any of the conditions your blood relatives have been treated for)

Diabetes	High Blood Pressure	Stroke	Heart Problems
Cancer	Arthritis/Joint Pain	Blindness	Cataracts
Glaucoma	Retinal Problems	Lazy/Crossed Eye	Breathing Problems

Please list any other diseases/problems not listed above:

____

DO YOU TAKE ANY MEDICATIONS? **Yes** **No**
(If you have circled Yes, please list your medications below)

____

____

____

____

ARE YOU ALLERGIC TO ANY MEDICATIONS? **Yes** **No**
(If you have circled Yes, please list them below)

____

EYE HISTORY (please circle):
Do you wear glasses for reading? **Yes** **No** Do you wear glasses for distance? **Yes** **No**
Have you ever had eye surgery? **Yes** **No** How old are your glasses? ______________
If you circled Yes above, please list the type of eye surgery and date:

____

____

Do you wear contact lenses? **Yes** **No** Do you sleep in them? **Yes** **No**
What kind are they? ______________ How old are they? ______________
Please list any eye injuries and date of injury: ______________________________

SOCIAL HISTORY:
Do you smoke? **Yes** **No** Do you live alone? **Yes** **No**
Do you drink alcohol? **Yes** **No** If you answered Yes, how often? ______________

PLEASE CIRCLE ANY EYE PROBLEMS YOU HAVE OR HAVE HAD:

Glaucoma	Lazy Eye	Macular Degeneration	
Loss of Vision	Blurred Vision	Flashing Lights	Dry Eye
Pain/Soreness	Tearing/Discharge	Dark Spots/Cobwebs	Redness
Itching/Burning	Light Sensitivity	Eyelid Bump	Cataracts