Medical History (Treated & Untreated) Check All That Apply	
AIDS/HIV	
Artificial Heart Valve	
Arthritis	
Artificial Joints	
Asthma	
Blindness	
Cancer (Type_____)	
Cataracts	
Diabetes (Type_____)	
Emphysema	
Epilepsy	
Eye Surgery (Date_____)	
Glaucoma	
Hemorrhaging	
Hepatitis (Type_____)	
High Cholesterol	
High Blood Pressure (Hypertension)	
Kidney Disease	
Lupus	
Macular Degeneration	
Migraine Headaches	
Multiple Sclerosis	
Pacemaker	
Retinal Disease	
Shingles	
Skin Condition (Type_____)	
Stroke	
Thyroid Condition(Type_____)	
Tuberculosis	

Medications

Please list any prescribed medications with dosage instructions:
If you have a prepared list, we can photocopy and attach it.
[ ] See attached list.

Medication	Dosage Instruction

Eye Health	
Blurred Vision at Near	
Blurred Vision at Distance	
Burning Eyes	
Crossed Eyes	
Discharge	
Dry Eyes	
Eye Injury	
Eye Strain	
Flashes	
Floaters or Spots	
Headaches	
Itching	
Watering Eyes	
Other	

Family Medical History	
Condition	Family Member
Blindness	
Cancer (Type_____)	
Diabetes (Type_____)	
Glaucoma	
Macular Degeneration	
Multiple Sclerosis	
Retinal Disease	
Stroke	
Tuberculosis	

Social

Do you Smoke? _____
Have you Ever Smoked? _____
When did you quit? _____

Are you pregnant? _____

Drug Related Allergies

[ ] No known drug allergies

Drug	Reaction