MEDICAL HISTORY INFORMATION

Last Name:	*First Name:*		*D.O.B.*	*Age:*
		Male ☐ Female ☐		

Past, Family, & Social History (Please check ALL appropriate boxes.)

Patient Past:
- Eye Injury: ☐
- Glaucoma: ☐
- Cataract: ☐
- Macular Degeneration: ☐
- Surgery: ☐
- Hypertension: ☐
- Diabetic: ☐
- Cancer: ☐

Family History:
- Glaucoma: ☐
- Cataract: ☐
- Macular Degeneration: ☐
- Surgery: ☐
- Hypertension: ☐
- Diabetic: ☐
- Cancer: ☐
- Other: ☐

Patient Social History:
- Smoke: ☐
- Alchohol: ☐
- Other: ☐

Occupational:
Do you have any work related special visual needs?
Y ☐ N ☐ If yes, please explain:

Do you have any of the following? (Please check ALL appropriate boxes.)

Allergic/Immunologic:
- ☐ **NONE**
- ☐ Environmental Allergy
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Other:

Gastrointestinal:
- ☐ **NONE**
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Digestive
- ☐ Other:

Integumentary/Skin:
- ☐ **NONE**
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Other:

Psychiatric:
- ☐ **NONE**
- ☐ Depression
- ☐ Panic Disorder
- ☐ Schizophrenia
- ☐ Other:

Cardiovascular:
- ☐ **NONE**
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Stroke
- ☐ Vascular Disease
- ☐ Other:

Endocrine:
- ☐ **NONE**
- ☐ Diabetes
- ☐ Thyroid
- ☐ Hormonal
- ☐ Other:

Musculoskeletal:
- ☐ **NONE**
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Ankylosing Spondylitis
- ☐ Other:

Respiratory:
- ☐ **NONE**
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Other:

Neurological:
- ☐ **NONE**
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Other:

Genitourinary:
- ☐ **NONE**
- ☐ STD
- ☐ Prostate
- ☐ Other:

Constitutional:
- ☐ **NONE**
- ☐ Developmental Disability
- ☐ Weight Loss
- ☐ Fever
- ☐ Fatigue
- ☐ Trauma
- ☐ Other:

Hematologic/Lymphatic:
- ☐ **NONE**
- ☐ Anemia
- ☐ Sickle Cell
- ☐ Blood Disease
- ☐ Cholesterol
- ☐ HIV
- ☐ Other:

Ear/Nose/Throat/Mouth:
- ☐ **NONE**
- ☐ Upper Resp. Tract Infect.
- ☐ Other:

Medications:

Eye Medications:

DRUG ALLERGIES:

Do you wear Glasses? ☐ Y ☐ N
Do you wear Contacts? ☐ Y ☐ N
Are you interested in Contacts? ☐ Y ☐ N
Are you interested in Refractive Surgery? ☐ Y ☐ N

Pharmacy you currently use?

Who is your Primary Care Doctor? Doctor's Phone # ?

Please list any Specialst (s) that you see: Doctor's Phone # ?

Signature: Date: