MEDICAL HISTORY

Name: _____ Date: _____

Date of Birth:_____

Current Ocular Symptoms

- ☐ Flashes
- ☐ Floaters
- ☐ Pain
- ☐ Redness
- ☐ Blurred vision
- ☐ Blind spot
- ☐ Light sensitivity
- ☐ Itchy eyes
- ☐ Dry eyes
- ☐ Watery eyes
- ☐ Vision loss
- ☐ Other _____

Past Ocular History

- ☐ Keratoconus
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Retinal Detachment
- ☐ Retinal Hole/Tear
- ☐ Macular Degeneration
- ☐ Diabetic Retinopathy
- ☐ Cataract Surgery
- ☐ Cornea Transplant
- ☐ Other _____

Does anyone in your **immediate family** have a history of any of the following?

- ☐ Diabetes
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Blindness
- ☐ Retinal detachment

What medications do you currently take?_____

_____

_____

Please list any medication allergies. _____

Do you use tobacco? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

Do you use illegal drugs? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No If yes, what brand? _____

PLEASE TURN OVER FOR SECOND PAGE

MEDICAL HISTORY

Name: _____ Date: _____

Please check the box next to any condition that you have or have had in the past.

Integumentary (Skin)
- ☐ Skin Cancer
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rosacea

Respiratory
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Tuberculosis
- ☐ Lung Cancer

Cardiovascular
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Attack
- ☐ Heart Disease

Gastrointestinal
- ☐ Liver Disease
- ☐ Crohn's Disease
- ☐ Ulcers

Genitourinary
- ☐ Kidney disease
- ☐ Prostate issues
- ☐ Bladder issues

Musculoskeletal
- ☐ Rheumatoid Arthritis
- ☐ Gout
- ☐ Osteoporosis

Neurological
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Migraines/Headaches
- ☐ Stroke (CVA)
- ☐ Seizures

Endocrine
- ☐ Diabetes
- ☐ Diabetic Suspect
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

Hematologic/Lymphatic
- ☐ AIDS/HIV
- ☐ Hepatitis
- ☐ Lupus

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar Disorder

☐ **I do not have any current or historical medical conditions.**

Please list any other medical history or give details regarding above conditions. _____

_____

_____

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