PATIENT MEDICAL INFORMATION AND HISTORY

NAME _____ DATE OF BIRTH _____ DATE _____

OCULAR HISTORY

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING DISORDERS?

	YES (CHECK ONE)	NO (CHECK ONE)
• GLAUCOMA	❑	❑
• CATARACTS	❑	❑
• CORNEAL DISEASE	❑	❑
• MACULAR DEGENERATION	❑	❑
• RETINAL DISEASE OR DETACHMENT	❑	❑
• OPTIC NERVE DISORDERS	❑	❑
• OTHER: _____		

- HAVE YOU EVER HAD EYE SURGERY? _____ IF YES, PLEASE EXPLAIN: _____

_____

- HAVE YOU EVER HAD ANY OCULAR INJURY? _____ IF YES, PLEASE EXPLAIN: _____

_____

OCULAR FAMILY HISTORY

PLEASE NOTE ANY FAMILY HISTORY (PARENTS, GRANDPARENTS, SIBLINGS, CHILDREN; LIVING OR DECEASED) FOR ANY OF THE FOLLOWING CONDITIONS:

	YES (CHECK ONE)	NO (CHECK ONE)
• GLAUCOMA	❑	❑
• CATARACTS	❑	❑
• MACULAR DEGENERATION	❑	❑
• RETINAL DISEASE OR DETACHMENT	❑	❑
• BLINDNESS	❑	❑
• OTHER: _____		

MEDICATIONS

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

- OCULAR (Including Eyedrops) : _____
- SYSTEMIC: _____

_____

_____

- PLEASE LIST ANY DRUG ALLERGIES: _____

GENERAL HEALTH HISTORY

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING DISORDERS?

	YES (CHECK ONE)	NO (CHECK ONE)
• HIGH BLOOD PRESSURE (HYPERTENSION)	❑	❑
• HIGH CHOLESTEROL	❑	❑
• HEART DISEASE	❑	❑
• HEART MURMUR	❑	❑
• HARDENING OF THE ARTERIES (ARTERIOSCLEROSIS)	❑	❑
• STROKE	❑	❑
• CHRONIC COUGH	❑	❑
• ALLERGIES / HAY FEVER	❑	❑
• SINUS CONGESTION	❑	❑
• DIABETES	❑	❑
• THYROID DISORDER	❑	❑
• GASTROINTESTINAL DISORDERS	❑	❑
• KIDNEY DISEASE	❑	❑
• ANEMIA	❑	❑
• BLOOD DISORDER	❑	❑
• IMMUNODEFICIENCY	❑	❑
• LYME DISEASE	❑	❑
• SKIN DISORDERS (ECZEMA, ROSACEA, ETC.)	❑	❑
• ARTHRITIS	❑	❑
• MUSCLE PAIN	❑	❑
• JOINT PAIN	❑	❑
• HEADACHES	❑	❑
• SEIZURES	❑	❑
• PSYCHIATRIC	❑	❑
• ASTHMA	❑	❑
• COPD	❑	❑
• ARE YOU CURRENTLY NURSING OR PREGNANT ?	❑	❑
• DO YOU USE TOBACCO ?	❑	❑