

Last Name _____ First Name _____ MI _____ Date: ____/____/____

Please answer the following questions about the patient's medical history:

1. Have you ever been treated for any medical conditions (i.e., diabetes, high blood pressure, arthritis, etc.)?
___ No ___ Yes, if yes please explain _____

2. Have you ever had any eye disease (i.e., glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?
___ No ___ Yes, if yes please explain _____

3. Have you ever had any eye surgery (lasik, refractive, etc.?) Please explain _____

4. Do you take any medications? ___ No ___ Yes, if yes, please list: _____

5. Do you have any drug allergies? ___ No ___ Yes, if yes, please list the drugs and the reactions that occur when you take the drugs: _____

6. Do you now, or have you ever had, any of the following problems? NO YES If yes, please explain.
Chronic Fever, unexpected weight loss/gain, fatigue _____ _____ _____
Ear/nose/throat problems (i.e., hearing loss, sinus problems) _____ _____ _____
Heart problems (i.e., chest pain, irregular heartbeat) _____ _____ _____
Respiratory problems (i.e., shortness of breath, wheezing, _____ _____ _____
asthma, bronchitis)
Gastrointestinal problems (i.e., heartburn, abdominal pain, _____ _____ _____
diarrhea)
Urinary problems (i.e., pain or discomfort, bladder infections) _____ _____ _____
Skin Disease (i.e., rashes, eczema, dermatitis) _____ _____ _____
Musculoskeletal problems (i.e., muscle aches, arthritis, _____ _____ _____
swollen joint)
Neurologic problems (i.e., numbness, weakness, paralysis, _____ _____ _____
headaches)
Psychiatric problems (i.e., depression, anxiety) _____ _____ _____
7. Do any medical or eye diseases run in your family (i.e., diabetes, high blood pressure cancer, glaucoma, macular degeneration)? ___ No ___ Yes If yes, please explain: _____

8. Do you smoke? ___ No ___ Yes If yes, how much per day: _____
9. Do you drink alcohol? ___ No ___ Yes If yes, how much: _____