Patient Name: _____ Today's Date: _____

Eye History:

Date of last eye exam: _____ By whom? _____

Do you wear Contact Lenses? Y / N If yes, which brand/type? _____

Reason for today's visit, please list concerns: _____

Medical History:

Name of medical doctor: _____ Phone #: _____

Date of last visit: _____ Are you pregnant or nursing? Y / N

Height: _____ Weight: _____

Do you:

Smoke	Y / N	Former smoker? Y / N	Amount/how long? _____
Drink Alcohol	Y / N		How often? _____
Use Drugs	Y / N		Type/how often? _____

List of current medications/dosage: _____

_____

Medical Allergies: _____

Do you have (or are being treated for) any of the following? (please circle)

Headaches/Migraines	High Blood Pressure	Diabetes: Type 1 or 2	Heart Disease
Seizures	Loss of Vision	Double Vision	Flashes/Floaters
Psychiatric Disorder	High Cholesterol	Sinus Congestion	Rheumatoid Arthritis
Emphysema	Joint/Muscle Pain	Cataracts	Glaucoma
Asthma	Thyroid Disorder	Anemia	Cancer: type? _____
Macular Degeneration	Immune Disorder	Bleeding Disorder	Kidney Disorder
HIV	Hepatitis	Other: _____	

Any Past eye surgeries/injuries? Which eye? _____

Past medical surgeries? _____

Diabetic Patients: Last A1c: _____ Last checked blood sugar? When? _____

Family History:

Please note any family history including parents, grandparents, siblings, children and **specify relationship**:

M-Mother; F-Father; S-Sister; B-Brother; GM-grandmother; GF-grandfather; D-daughter; SN-son; A-aunt; U-uncle

Cancer	Blindness (cause?) _____	Lupus	Diabetes
Cataracts	Macular Degeneration	Heart Disease	High Blood Pressure
Glaucoma	Retinal Disease	Kidney Disease	High Cholesterol