MEDICAL HISTORY AND STATUS:

Name: _____ Date of birth: _____ Date completed: _____

1. Have you ever been treated for any medical condition? (diabetes, high blood pressure, arthritis, etc.)
   Yes____ No ____ If yes, please explain: _____
2. Have you ever been treated for any eye disorder? (glaucoma, cataract, lazy eye, retinal detachment, etc.)
   Yes ___ No ___ If yes, please explain: _____
3. Have you ever had any surgery?
   Yes ___ No ___ If yes, please provide date and reason: _____
   _____
4. Have you ever been hospitalized?
   Yes ___ No ___ If yes, please provide date and reason: _____
   _____
5. Do you take any medications?
   Yes ___ No ___ If yes, please list: _____
   _____
6. Do you have any drug or food allergies?
   Yes ___ No ___ If yes, please list: _____

REVIEW OF SYSTEMS:

Do you currently have any of the following problems:	Yes	No	If yes, please explain:
Chronic fever, unexpected weight loss/gain, fatigue:	___	___	_____
Ear/nose/throat problems (hearing loss, sinus problems, etc)	___	___	_____
Heart problems (chest pain, irregular heart beat)	___	___	_____
Respiratory problems (shortness of breath, wheezing, coughing)	___	___	_____
Gastrointestinal problems (heartburn, abdominal pain, diarrhea Or vomiting)	___	___	_____
Urinary problems (pain, discomfort, blood in urine)	___	___	_____
Skin problems (rashes, excessive dryness, acne rosacea)	___	___	_____
Musculloskeletal problems (muscle aches, pain, swollen joints)	___	___	_____
Neurological problems (numbness, weakness, headaches, paralysis)	___	___	_____
Psychiatric problems (depression, anxiety)	___	___	_____

FAMILY AND SOCIAL HISTORY:

Do any medical or eye disorders run in your family? (diabetes, high blood pressure, cancer, glaucoma, macular degeneration, cataracts)

Yes ____ No ____ If yes, please explain: _____
_____

Do you smoke? Yes ____ No ____ If yes, how much: _____

Do you consume alcohol? Yes ____ No ____ If yes, how much / how often: _____

If employed, how many hours per week do you work? _____

Who is your primary care provider (family doctor)? _____

_____

Reviewing Doctor's Signature Date Subsequent Review Date/Initials Date/Initials