MEDICAL HISTORY

NAME:_____ DOB:_____AGE:_____ DATE:_____

PRIMARY CARE DOCTOR/ PHONE #:_____

PHARMACY/ PHONE#:_____

HAVE YOU EVER BEEN TREATED/ INFORMED YOU HAVE ANY OF THE FOLLOWING?

	YES	NO		YES	NO
PREVIOUS EYE INJURIES	___	___	HIGH BLOOD PRESSURE	___	___
GLAUCOMA	___	___	SEASONAL ALLERGIES	___	___
CATARACT	___	___	DIABETES	___	___
RETINAL DETACHMENT	___	___	HEART PROBLEMS	___	___
MACULAR DEGENERATION	___	___	ASTHMA	___	___
DIABETIC RETINOPATHY	___	___	EMPHYSEMA	___	___
AMBLYOPIA	___	___	ARTHRITIS	___	___
LAZY/ CROSS EYE	___	___	THYROID DISEASE	___	___
DRY EYES	___	___	HEPATITIS or LIVER DISEASE	___	___
CORNEAL DISEASE	___	___	KIDNEY PROBLEMS	___	___
UVEITIS	___	___	TUBERCULOSIS	___	___
LASIK	___	___	BRUISE EASILY	___	___
RK	___	___	AUTOIMMUNE DISEASE	___	___
OTHER_____			(LUPUS, SJOGREN'S, RHEUMATOID, ETC)		

HAS ANYONE IN YOUR IMMEDIATE FAMILY BEEN TREATED/ INFORMED THEY HAD ANY OF THESE?

	YES	NO	RELATIVE
GLAUCOMA	___	___	_____
CATARACT	___	___	_____
RETINAL DETACHMENT	___	___	_____
MACULAR DEGENERATION	___	___	_____
AMBLYOPIA	___	___	_____
LAZY/ CROSS EYE	___	___	_____

DO YOU SMOKE?YES__ NO__ PACKS PER DAY___ DO YOU DRINK?YES__NO__ HOW MUCH?_____

ALLERGIES:_____

EYE MEDICATIONS:_____

MEDICATIONS:_____

_____

_____

ARE YOU PREGNANT? YES___ NO___ N/A___

HAVE YOU EVER WORN CONTACT LENSES?_____ WHAT TYPE/BRAND?_____