

MEDICAL HISTORY

Name: _____ Date: _____

Date of Birth: _____

Current Ocular Symptoms

- Flashes
- Floaters
- Pain
- Redness
- Blurred vision
- Blind spot
- Light sensitivity
- Itchy eyes
- Dry eyes
- Watery eyes
- Vision loss
- Other _____

Past Ocular History

- Keratoconus
- Glaucoma
- Cataracts
- Retinal Detachment
- Retinal Hole/Tear
- Macular Degeneration
- Diabetic Retinopathy
- Cataract Surgery
- Cornea Transplant
- Other _____

PLEASE TURN OVER FOR SECOND PAGE



MEDICAL HISTORY

Name: _____ Date: _____

Does anyone in your **immediate family** have a history of any of the following?

- Diabetes
- Glaucoma
- Macular degeneration
- Blindness
- Retinal detachment

What medications do you currently take? _____

Please list any medication allergies. _____

Do you use tobacco? Yes No

Do you drink alcohol? Yes No

Do you use illegal drugs? Yes No

Do you currently wear contact lenses? Yes No If yes, what brand? _____

Please check the box next to any condition that you have or have had in the past.

Integumentary (Skin)

- Skin Cancer
- Eczema
- Psoriasis
- Rosacea

Respiratory

- Asthma
- Emphysema
- COPD
- Tuberculosis
- Lung Cancer

Cardiovascular

- High Blood Pressure
- High Cholesterol
- Heart Attack
- Heart Disease

Gastrointestinal

- Liver Disease
- Crohn's Disease
- Ulcers

Genitourinary

- Kidney disease
- Prostate issues
- Bladder issues

Musculoskeletal

- Rheumatoid Arthritis
- Gout
- Osteoporosis

Neurological

- Multiple Sclerosis
- Parkinson's
- Migraines/Headaches

MEDICAL HISTORY

Name: _____ Date: _____

- Stroke (CVA)
- Seizures

Endocrine

- Diabetes
- Diabetic Suspect
- Hyperthyroidism
- Hypothyroidism

Hematologic/Lymphatic

- I do not have any current or historical medical conditions.

- AIDS/HIV
- Hepatitis
- Lupus

Psychiatric

- Anxiety
- Depression
- Bipolar Disorder

Please list any other medical history or give details regarding above conditions. _____
