Patient Name: _____ Address _____

Date: _____ Date of Birth: _____ Do you drink Alcohol? Yes / No

(Please circle)
Working / Retired / Disabled Smoker / Nonsmoker Driver / Day Driver only / Non-driver

Are you having any eye problems? (Please list)_____

Do these diseases run in your immediate family? (mother, father, brother, or sister)
(Please circle & note relationships)

	Relationship		Relationship		Relationship
Cataract	_____	Retinal Disease	_____	Diabetes	_____
Glaucoma	_____	Other Eye Disease	_____		

Have you ever been told you have any of the following eye conditions? (Please circle all that apply)

Cataracts Glaucoma Diabetic Retinopathy Crossed/Lazy Eye

Macular Degeneration Glasses/Contacts

Have you ever had an eye injury? Yes / No If yes, please describe: _____

List any of your previous eye surgery or laser treatment: _____

_____

Have you had any of the following medical conditions? (Please circle all that apply)

Arthritis Asthma Cancer COPD Diabetes Heart Disease Irregular Heart Beat

High Blood Pressure Migraines Sleep Apnea Stroke/TIA Other: _____

Do you currently have any problems in the following areas?	Yes	No
GENERAL / CONSTITUTION (Fever, Headache, Weight loss, Weakness)	☐	☐
EARS / NOSE / THROAT (Hard of Hearing, Dry mouth, Frequent Headache)	☐	☐
CARDIOVASCULAR (Chest Pain, High Blood Pressure, Irregular Heart Beat)	☐	☐
RESPIRATORY (COPD, Shortness of Breath)	☐	☐
GASTROINTESTINAL (Heartburn, Vomiting, Diarrhea)	☐	☐
MUSCLES & BONES (Joint Pain, Cramps, Arthritis)	☐	☐
NEUROLOGIC (Stroke, Numbness, Seizures, Weakness)	☐	☐
ENDOCRINE (Diabetes, Thyroid Condition)	☐	☐
BLOOD / LYMPH (Bleeding, Bruising, Anemia)	☐	☐
PSYCHIATRIC (Alzheimer's, Depression, Poor Memory)	☐	☐

XXXXXXXXXXXXXXXXX OFFICE USE ONLY BELOW THIS LINE XXXXXXXXXXXXXXXXX

Type of surgery & date	Type of surgery & date	Type of surgery and date
_____	_____	_____
_____	_____	_____

Referring Doctor _____ Primary Care _____ Optometrist _____

Allergies: _____

Medications:_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____