Name:_____ **Date**_____
Primary Care Physician:_____ **Date of Birth**_____
Technician/Doctor Reviewing:_____ **on**_____

List All

Allergies:_____
_____

Medications(including aspirin, hormones and herbals) Use back of sheet if necessary:_____
_____
_____
_____

Eye drops (prescription or non):_____

Do you smoke? Y or N **If you work, how many hours per week?** _____

Circle All That Apply

Do *you* have a history of *any* of the following:
High Blood Pressure Stroke/TIA Heart Attack Congestive Heart Failure Asthma Emphysema Diabetes Cancer Migraines Glaucoma Lazy Eye Retinal Detachment Macular Degeneration

Is there a *family* history of any of the following:
Diabetes Hypertension Cancer Glaucoma Retinal detachment Macular Degeneration Other:_____
If yes, whom_____

Any problems with other organ systems:
Fever Weight Loss/Gain Urinary-Pain w/blood Ear/Nose/Throat Skin Rashes Lesions, where_____ Heart/Chest Pain Irregular Pulse Skeletal/Joint Pain Muscle Aches Wheezing/Coughing Shortness of breath Neuro-headache Weakness GI/Stomach Pain Diarrhea Blood in Stool Depression/Anxiety Other:_____

Any other medical problems:_____

Any Surgeries *<u>including</u>* eye or eye disease (use the back of sheet)_____
_____

Do you have poor vision in either eye EVEN WITH GLASSES? If yes, please explain:_____