Name _____ Date_____

Past Eye History

Have you had any eye surgery? Yes___ No ___

If yes, please list what type, the date of the surgery and the name of the surgeon.

_____

Do you have an intraocular lens or implant? Yes___ No___

Do you use eye drops? Yes___ No ___

If yes, please list them. _____

Past Medical History

Are you allergic to any medications? Yes ___ No ___

If yes, please list them. _____

Are you currently taking any medication? Yes___ No ___

If yes, please list them. _____

_____

_____

Please list any surgeries that you have had (not including eye surgery)

_____

_____

_____

Have you ever had (or do you now have) any of the following:

If yes please list the dates (such as diabetes since 1997 or stroke in May, 1990) and give other important information

ROS/Endo

Diabetes _____Yes___No___ _____

Thyroid disease _____ Yes___No___ _____

High blood pressure_____ Yes___No___ _____

Cardiovascular

Heart disease_____ Yes___No___ _____

Heart attack_____ Yes___No___ _____

Bypass surgery_____ Yes___No___ _____

Congestive Failure_____ Yes___No___ _____

Irregular beat_____ Yes___No___ _____

Chest Pain_____ Yes___No___ _____

Respiratory

Lung disease_____ Yes___No___ _____

Asthma_____ Yes___No___ _____

Emphysema_____ Yes___No___ _____

Tuberculosis_____ Yes___No___ _____

Shortness of breath____ Yes___No___ _____

Gastrointestinal

Stomach problems_____ Yes___No___ _____

Ulcers_____ Yes___No___ _____

Stomach pain_____ Yes___No___ _____

Liver disease_____ Yes___No___ _____

Hepatitis_____ Yes___No___ _____

Yellow jaundice_____ Yes___No___ _____

Bowel changes or problems Yes___No___ _____

MS

Arthritis_____ Yes___No___ _____

Muscle weakness_____ Yes___No___ _____

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reviewed

_____ _____ _____

SEE OTHER SIDE

Neurologic problems_____Yes___No___ _____
Stroke_____ Yes___No___ _____
Paralysis_____ Yes___No___ _____
Numbness or tingling__Yes___No___ _____
Headache_____ Yes___No___ _____
Kidney problems_____ Yes___No___ _____
Stones_____Yes___No___ _____
Failure_____ Yes___No___ _____
Trouble urinating_____Yes___No___ _____
Skin Problems_____Yes___ No___ _____
Rash_____Yes___No___ _____
Changes in skin color_ Yes___No___ _____
Anemia_____ Yes___No___ _____
Bleeding trouble_____ Yes___No___ _____
Blood transfusion_____ Yes___No___ _____
Trouble hearing_____ Yes___No___ _____
Dizziness/vertigo_____ Yes___No___ _____
Ringing in ears_____ Yes___No___ _____
Cancer_____Yes___No___ _____
Infectious disease_____ Yes___No___ _____
Organ transplant_____ Yes___No___ _____
Mental illness_____ Yes___No___ _____

Please list any disorder or medical conditions which you have or have had in the past which have not been noted above. _____
_____
_____
_____

Do you have a family history of:

Diabetes	Yes___No___	Glaucoma	Yes___No___
Stroke or Heart attack	Yes___No___	Blindness	Yes___No___
Macular degeneration	Yes___No___	Other:_____	
Retinal Detachment	Yes___No___	_____	

Marital status: (circle one) single married widowed

Current Occupation:_____
If retired, please list previous occupation(s)_____

What are your hobbies/interests?_____

Have you ever smoked? Yes___No___quit___(when?_____)
If yes, how much and for how long?_____

Do you drink alcohol? Yes___No___
If yes, how much in a typical day?_____

Neruologic Genitourinary Skin Heme ENT Const Psy PMH (cont'd) Family History Social History