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NAME: _____ DATE: _____

Date of Birth: _____/_____/_____

List Allergies to Medications: _____

Circle the Appropriate Answer:

1. Do you have glaucoma?	Yes	No
2. Do you have cataracts?	Yes	No
3. Have you ever had eye surgery?	Yes	No
4. Have you ever had an eye injury?	Yes	No
5. Have you ever had temporary loss of vision?	Yes	No
6. Have you ever been told that you have a lazy eye?	Yes	No
7. Do you have diabetes?	Yes	No
8. Do you have high blood pressure?	Yes	No
9. Do you have heart trouble?	Yes	No
10. Do you have lung problems?	Yes	No
11. Have you ever had a stroke?	Yes	No
12. Have you ever had stomach or intestinal problems?	Yes	No
13. Have you ever had a urinary tract problem?	Yes	No
14. Have you ever been diagnosed with cancer?	Yes	No
15. Have you ever been diagnosed with thyroid disease?	Yes	No
16. Do you have bleeding problems?	Yes	No
17. Do you have arthritis?	Yes	No
18. Have you ever been hospitalized?	Yes	No

19. List any other illnesses or conditions you are being followed for: _____

_____

20. List any previous surgeries and dates:

_____

(over)

21. What is you current occupation? _____

22. If you smoke or have ever smoked, write down:

the number of packs per day _____ and

the number of years you smoked _____ and

if you stopped, when? _____

23. List all of your current medications and dosages: _____

_____

_____

_____

24. Do you have a family history of:

• Diabetes	Yes	No
• Retinal Detachments	Yes	No
• Glaucoma	Yes	No
• Macular Degeneration	Yes	No
• Crossed or Lazy Eye	Yes	No

Patient Signature: _____

FOR OFFICE USE ONLY

Physician Signature: _____ Date: _____