Medical History

Please fill out this form and return it to the front desk.

Name: _____ Date:_____ Age:_____

Reason for today's visit:

_____

List all medications you take: (or attach list)

_____

_____

_____

YES	NO	
❑	❑	Are you allergic to any medications? If yes, please list. _____
❑	❑	Do you have diabetes?
❑	❑	Do you wear eyeglasses or contacts? If yes, how long? _____
❑	❑	Have you had any eye infections?
❑	❑	Have you been told you have glaucoma?
❑	❑	Have you been told you have cataracts?
❑	❑	Have you had "crossed eye" or "lazy eye"?
❑	❑	Have you had any eye injuries?
❑	❑	Do you have high blood pressure?
❑	❑	Have you had heart disease?
❑	❑	Have you had a stroke?
❑	❑	Have you or do you have cancer?
❑	❑	Do you have any blood disease or bleeding problems?
❑	❑	Do you smoke?
❑	❑	Do you drink alcohol daily?
❑	❑	Have you had any type of eye surgery? If yes, please list _____
❑	❑	Have you had any other major illnesses? If yes, please list _____

Family History

❑	❑	Does anyone in your family have CATARACTS, GLAUCOMA, LAZY EYE, or RETINAL DETACHMENT, please explain _____ _____
❑	❑	Do any major illnesses or diseases run in your family? If yes, please list._____