Medical/ Eye Health Information Name_____ Date_____

Primary Care Physician_____Clinic_____Last seen_____

Have you been diagnosed or are being treated for the following health problems:

__Allergies
__Cancer
__Ears/nose/throat
__High Blood Pressure
__Neurological
__Thyroid high/low
__Arthritis
__Cholesterol
__Endocrine
__Headaches
__Psychological
__Unusual Weight Gain/Loss
__Blood/Lymph
__Diabetes type 1 / 2
__Eczema/Rashes
__Kidney
__Respiratory
__Bronchitis
__Digestive
__Genitourinary
__Muscle/Bone
__Sinus

Height_____ Weight_____ Blood Pressure_____Pulse_____

Do you use tobacco? Y / N Former Tobacco use Y/N How long ago_____

Alcohol use : None_____ Occasional_____ Alcohol Dependent_____

PLEASE LIST YOUR CURRENT MEDICATIONS (Including Aspirin, Vitamins etc.....)

Medication	For what condition	Medication	For what condition

Explanation if needed:_____

Allergies to Medication: Yes/No Which Ones/Reactions?_____

Other health conditions:_____

Family History (Please check any apply)

__High Blood Pressure Relation_____
__Diabetes Relation _____
__Glaucoma Relation_____
__Blindness Relation_____
__Macular Degeneration Relation _____
__Retinal detachment Relation_____
__Cataracts Relation_____
__Corneal Problems Relation

Have you ever experienced, been diagnosed or been treated for any of the following eye conditions?

__Blurry Vision
__Flash of Light
__Macular Degeneration
__Double Vision
__Grittiness
__Light sensitivity
__Cataracts
__Glaucoma
__Tearing
__Corneal Abrasion
__Iritis /Uveitis
__Night Driving
__Crossed Eye
__Headaches
__Burning
__Eye Injury
__Lazy Eye
__Eye Infections
__Itchiness
__Retinal Detachment
__Floaters/Spots
__Dryness

Please describe any eye surgeries/Injuries/disorders:_____
Date of last eye exam_____ by whom_____
Do your wear glasses Y___N___ Contact Lenses Y__N__ What type_____