

Medical & Eye History

Patient's Name _____ Date _____

PERSONAL EYE HISTORY

Do you have or have you ever had:

	Year Diagnosed		Type
Glaucoma	Y/N _____	Eye Infections	Y/N _____
Cataracts	Y/N _____	Eye Injuries	Y/N _____
Macular Degeneration	Y/N _____	Eye Surgeries	Y/N _____
Amblyopia (lazy eye)	Y/N _____	Corneal Conditions	Y/N _____
Strabismus (eye turn)	Y/N _____	Other Eye Conditions	Y/N _____
Retinal Disease	Y/N _____		

PERSONAL MEDICAL HISTORY

Do you have or have you ever had:

	Year Diagnosed		Year Diagnosed
Diabetes	Y/N _____	Asthma	Y/N _____
High Blood Pressure	Y/N _____	Allergies	Y/N _____
Heart Disease	Y/N _____	HIV/AIDS	Y/N _____
Thyroid Condition	Y/N _____	Autoimmune Disease	Y/N _____
Stroke	Y/N _____		Type _____
Multiple Sclerosis	Y/N _____	Cancer	Y/N _____
Migraine Headaches	Y/N _____		Type _____
Currently Pregnant	Y/N _____	Other:	_____

FAMILY HISTORY

Does anyone in your family (blood related) have or ever had:

	Who		Who
Glaucoma	Y/N _____	Diabetes	Y/N _____
Cataracts	Y/N _____	High Blood Pressure	Y/N _____
Macular Degeneration	Y/N _____	Heart Disease	Y/N _____
Retinal Disease	Y/N _____	Stroke	Y/N _____
Lazy/Crossed Eye	Y/N _____	Cancer	Y/N _____
Blindness	Y/N _____		Type _____
Other Eye Disease	Y/N _____	Other	_____

PERSONAL SOCIAL AND MEDICATION HISTORY

Do you use: Cigarettes/tobacco: Y/N Alcohol: Y/N Other Substance(s): Y/N

Do you have any medication allergies? Y/N

Please list medical allergies and what happens: _____

Please list any/all medications you are currently taking or circle NO MEDS:

Medications:	For What Condition:
_____	_____
_____	_____

Name of Family Doctor & date last seen:
