Patient Name _____ Today's Date:_____

Last Eye Exam:_____ Last Medical Exam:_____

Primary Physician:_____

MEDICAL HISTORY: Do you currently have, or have you ever had, any of the following?

Anxiety	☐Yes	☐No	Diabetes Type 2	☐Yes	☐No
Osteoarthritis	☐Yes	☐No	Renal Disease	☐Yes	☐No
Rheumatoid Arthritis	☐Yes	☐No	Acid Reflux	☐Yes	☐No
Asthma	☐Yes	☐No	Hearing Loss	☐Yes	☐No
Irregular Heartbeat	☐Yes	☐No	Hepatitis	☐Yes	☐No
Bone Marrow Transplant	☐Yes	☐No	Hypertension	☐Yes	☐No
Prostate Disease	☐Yes	☐No	HIV/AIDS	☐Yes	☐No
Breast Cancer	☐Yes	☐No	High Cholesterol	☐Yes	☐No
Colon Cancer	☐Yes	☐No	Hyperthyroid	☐Yes	☐No
Lung Cancer	☐Yes	☐No	Hypothyroid	☐Yes	☐No
Prostate Cancer	☐Yes	☐No	Leukemia	☐Yes	☐No
COPD	☐Yes	☐No	Lymphoma	☐Yes	☐No
Coronary Artery Disease	☐Yes	☐No	Radiation	☐Yes	☐No
Depression	☐Yes	☐No	Seizures	☐Yes	☐No
Diabetes Type 1	☐Yes	☐No	Stroke	☐Yes	☐No

Please list any other medical conditions you have that are not listed above:

If Diabetic, last HbA1c result _____ Last Blood Sugar_____
Please list any medications you are currently taking:

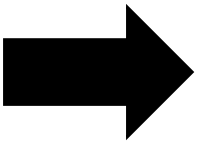
If you have any known allergies, please list:

If female, are you pregnant or nursing? ☐Yes ☐No

OCULAR HISTORY: Do you currently have, or have you ever had, any of the following?

SURGERY:

Cataracts	☐Yes	☐No	Lasik Surgery	☐Yes	☐No
Macular Degeneration	☐Yes	☐No	Cataract Surgery	☐Yes	☐No
Dry Eyes	☐Yes	☐No	Corneal Transplant	☐Yes	☐No
Retinal Tear (Detachment)	☐Yes	☐No	Injection	☐Yes	☐No
Floaters	☐Yes	☐No	Lid Surgery	☐Yes	☐No
Lazy Eye	☐Yes	☐No	Glaucoma Surgery	☐Yes	☐No
Glaucoma	☐Yes	☐No	Laser Surgery	☐Yes	☐No
Eye Injury	☐Yes	☐No	Eye Turn Surgery	☐Yes	☐No
Eye Turn	☐Yes	☐No			



FAMILY HISTORY: (Include family history of parents, grandparents, and siblings)

Blindness	If yes, list:
Macular Degeneration	If yes, list:
Eye Turn	If yes, list:
Retinal Detachment	If yes, list:
Glaucoma	If yes, list:
Diabetes	If yes, list:
Lazy Eye	If yes, list:
Hypertension	If yes, list: