Name______________________________________ Date of birth____________________

FAMILY AND PERSONAL HISTORY

Please note any family history for the following conditions:

Disease/Condition	self	relative	none
Blindness			
Cataract			
Crossed Eyes			
Glaucoma			
Macular Degeneration			
Retinal Detachment/Disease			
Diabetes			
Heart Disease			
High Blood Pressure (Hypertension)			
Cancer			
Kidney Disease			
Lupus			
Thyroid			
Arthritis			
Other			

Problem details/Surgeries

Do you currently have any problems in the following areas? If YES please provide additional information

	YES	NO
EYES (poor vision, eye pain, tearing, redness, etc.)		
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)		
EARS, NOSE, THROAT (heard of hearing, stuffy nose, earache, cough, dry mouth, etc.)		
CARDIOVASCULAR (high BP, racing pulse, etc.)		
RESPIRATORY (congestion, wheezing, short of breath, etc.)		
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)		
FEMALE Are you pregnant? Nursing?		
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc)		
SKIN (pimples, warts, growths, rash, etc.)		
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)		
PSYCHIATRIC (anxiety, depression, insomnia)		
ENDOCRINE (diabetes, hypothyroid, etc.)		
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)		
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)		

Primary Care Physician ____________________ Phone ____________

Pharmacy ____________________ Phone ____________

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? YES NO

Do you drink alcohol? YES NO

If yes, how much? ____________________

Do you smoke? YES NO

If yes, how much ____________________

How many years ____________________

Reviewed and updated

____________ ____________

____________ ____________