Medical History

Patient Name: _____

Who is your family physician? _____

Have you ever been treated/informed you have any of the below?

	Yes	No		Yes	No
Previous Eye Injuries	___	___	High Blood Pressure	___	___
Glaucoma	___	___	Seasonal Allergies	___	___
Cataract	___	___	Diabetes	___	___
Retinal Detachment	___	___	Heart Problems	___	___
Macular Degeneration	___	___	Asthma	___	___
Diabetic Retinopathy	___	___	Emphysema	___	___
Amblyopia	___	___	Arthritis	___	___
Lazy/Cross Eye	___	___	Thyroid Disease	___	___
Dry Eyes	___	___	Hepatitis or Liver Disease	___	___
Corneal Disease	___	___	Kidney Problems	___	___
Uveitis	___	___	Tuberculosis	___	___
Lasik	___	___	Bruise Easily	___	___
RK	___	___	Autoimmune Disease (Lupus, Sjogren's, Rheumatoid)	___	___

List other medical conditions that apply to you _____

Has anyone in your immediate family ever been treated or informed they had any of the following?

	Yes	No	Relative
Glaucoma	___	___	_____
Cataract	___	___	_____
Retinal Detachment	___	___	_____
Macular Degeneration	___	___	_____
Amblyopia	___	___	_____
Lazy/cross eye	___	___	_____

Do you smoke? Yes ___ No___ Packs Per Day ____ Do you drink? Yes ___ No___ How much? _____

Allergies: _____

Eye Medications: _____

Medications: _____

_____

_____

Are you pregnant? ___ Yes ___ No ___ N/A

Have you ever worn contact lenses? _____ Type: _____