

**Medical History**

Today's Date : \_\_\_\_\_

Do you have any allergies to medications? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, explain: \_\_\_\_\_

List any medications you take (including oral contraceptives, aspirin, over the counter medications or home remedies):  
\_\_\_\_\_  
\_\_\_\_\_

List all major injuries, surgeries and/or hospitalizations you have had: \_\_\_\_\_  
\_\_\_\_\_

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury:  
\_\_\_\_\_  
\_\_\_\_\_

Are you pregnant and/or nursing? No Yes NA  
Do you wear glasses? No Yes If yes, how old is your present pair of lenses? \_\_\_\_\_  
Do you wear contact lenses? No Yes If yes, how old is your present pair of lenses? \_\_\_\_\_  
Type of contact lenses: rigid soft extended wear other Are they comfortable? No Yes

**Family History**

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions:

| Disease/Condition          | No                       | Yes                      | Unknown                  | Relationship to You |
|----------------------------|--------------------------|--------------------------|--------------------------|---------------------|
| Blindness                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Cataract                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Crossed Eyes               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Glaucoma                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Macular Degeneration       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Retinal Detachment/Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Arthritis                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Cancer                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Diabetes                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Heart Disease              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| High Blood Pressure        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Kidney Disease             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Lupus                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Thyroid Disease            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Other _____                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |

**Social History** (This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.)

Yes, I would prefer to discuss my social history information directly with my doctor.

Do you drive? No Yes If yes, do you have visual difficulty when driving? No Yes

If yes, please describe: \_\_\_\_\_

Do you use tobacco products? No Yes If yes, type/amount/how long:

Do you drink alcohol? No Yes If yes, type/amount/how long:

Do you use illegal drugs? No Yes If yes, type/amount/how long:

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas: (if unknown then leave blank)

Table with 5 columns: System, No, Yes, No, Yes. Rows include constitutional, integumentary (skin), neurological, eyes, endocrine, Ears, Nose, Mouth, Throat, Respiratory, Vascular/cardiovascular, Gastrointestinal, Genitourinary, Bones/joints/muscles, Lymphatic/hematologic, Allergic/immunologic, and Psychiatric.

If you answered yes to any of the above or have a condition not listed, please explain and list medications:

Horizontal lines for providing explanations and listing medications.