Name_____ **DOB**_____ **Date**_____

Do you have a history of any ocular surgeries, injuries, diseases, or other eye issues? ***Y*** ***N***

If yes, please explain:_____

Do you have any of the following medical conditions?

Diabetes……Y N **Type I or Type II:_____** **Recent Blood Sugar:_____** **Last A1c:_____**

Seasonal allergies……	Y	N	Thyroid disease……..	Y	N	Diabetes……..	Y	N
Sinusitis/Congestion……..	Y	N	Asthma……	Y	N	Heart disease……..	Y	N
Dry Mouth……..	Y	N	COPD…….....	Y	N	High blood pressure..	Y	N
Headaches/Migraines……..	Y	N	Emphysema……	Y	N	High cholesterol……	Y	N
Stroke……..	Y	N	Sleep apnea……	Y	N	Rosacea/psoriasis….	Y	N
IBS/Ulcerative colitis/Crohn's…	Y	N	Fibromyalgia……...	Y	N	Bleeding disorder..…	Y	N
Kidney/Bladder disease……..	Y	N	Rheumatoid arthritis..…	Y	N	Anemia……..	Y	N
Liver disease……..	Y	N	Weight loss/gain….....	Y	N	Cancer……..	Y	N
Pregnancy……..	Y	N	Multiple Sclerosis……	Y	N	Type_____		

Other/Notes: _____

Do any of your immediate family members have these diseases:

			Circle			
Macular degeneration……	Y	N	Mother	Father	Sibling	Grandparent
Glaucoma……	Y	N	Mother	Father	Sibling	Grandparent
Blindness……	Y	N	Mother	Father	Sibling	Grandparent
Cancer……	Y	N	Mother	Father	Sibling	Grandparent
Diabetes……	Y	N	Mother	Father	Sibling	Grandparent
Thyroid disease……	Y	N	Mother	Father	Sibling	Grandparent
Heart disease……	Y	N	Mother	Father	Sibling	Grandparent
Arthritis……	Y	N	Mother	Father	Sibling	Grandparent

Medications you are currently taking:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies to medications:

_____ _____

_____ _____

_____ _____