

DATE _____

NAME _____

DATE OF BIRTH _____ OCCUPATION _____

REFERRING DOCTOR? _____ FAMILY DOCTOR _____

PLEASE CIRCLE ALL QUESTIONS EITHER **YES** OR **NO**

HAVE YOU HAD OR DO YOU HAVE:

DO YOU HAVE ANY ALLERGIES TO:

- YES NO Diabetes
- YES NO High blood pressure
- YES NO Heart disease
- YES NO High cholesterol
- YES NO Asthma/emphysema/other
- YES NO Sleep apnea
- YES NO Brain disorder/stroke/MS/other
- YES NO Thyroid disease
- YES NO Musculoskeletal disease/arthritis
- YES NO Ear,nose,throat/sinus disease
- YES NO Gastrointestinal disease
- YES NO Kidney/urinary disease
- YES NO Unexpected weight loss
- YES NO Psychiatric disease/depression
- YES NO Cancer
- YES NO Skin problems
- YES NO Are you HIV positive/have AIDS?
- YES NO Do you smoke? (How much? _____)
- YES NO Have you smoked in the past?
- YES NO Do you drink alcohol?
- YES NO Recent hospitalization?
- YES NO Recent surgeries?
- YES NO Are you pregnant?
- YES NO Have you ever taken Prednisone/steroids?

- YES NO Medications
- YES NO Food
- YES NO Eye drops
- _____
- _____
- _____

FAMILY HISTORY

Does your FAMILY have a history of:

- YES NO Macular degeneration
- YES NO Glaucoma
- YES NO Other eye diseases
- YES NO Other medical diseases (such as cancer, heart disease, stroke, etc.)

If yes, please explain: _____

PLEASE LIST YOUR CURRENT MEDICATIONS:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

UPDATE: OFFICE USE ONLY

