

Today's Date: _____

Name: _____



General Medical/Social History

Do you currently have or have you ever had diseases or conditions of: (Please circle YES or NO)

Aids/ HIV +	Yes	No	Thyroid Hypo/Hypo	Yes	No	
Cancer	Yes	No	Diabetes	Yes	No	
High Blood Pressure	Yes	No	Asthma/COPD	Which type: _____	Yes	No
Heart Disease/Attack	Yes	No	Sickle Cell	Yes	No	
High Cholesterol	Yes	No	Ulcerative Colitis	Yes	No	
Arthritis	Yes	No	Psych/Emotional Disorder	Yes	No	
Premature Birth	Yes	No	Skin Condition	Yes	No	
Gallbladder	Yes	No	Lupus	Yes	No	
Genetic Defects	Yes	No	Organ Transplant	Yes	No	
Renal Dialysis	Yes	No	Parkinson's	Yes	No	
Headache/Migraine	Yes	No	Anemia	Yes	No	
Hearing/Speech Problems	Yes	No	Multiple Sclerosis	Yes	No	
Stroke/TIA	Yes	No	Alzheimer's/Dementia	Yes	No	
Hepatitis	Yes	No	Pregnant/Nursing	Yes	No	
Rheumatoid Arthritis	Yes	No	ADD/ADHD	Yes	No	
Epilepsy/Seizures	Yes	No				

Please explain any "YES" answers: _____

Authorization of Health Information

Name of Relative/ friend we can discuss your medical needs with if necessary

Name: _____ Relationship: _____ Phone #: (____) _____

Name: _____ Relationship: _____ Phone #: (____) _____



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Your Eye History

Do you currently have or have you ever had diseases or conditions of: (Please circle YES or NO)

Cataracts	Yes	No	Blurred Vision	Yes	No
Glaucoma	Yes	No	Watery Eyes	Yes	No
Retinal Detachment/Disease	Yes	No	Eye Pain	Yes	No
Macular Degeneration	Yes	No	Flashes or Floaters	Yes	No
Diabetic Retinopathy	Yes	No	Halos	Yes	No
Corneal Disease	Yes	No	Seasonal Allergies	Yes	No
Previous Eye Surgery	Yes	No	Cross/Lazy Eye	Yes	No
Dry Eyes	Yes	No	Loss of Vision	Yes	No

Please explain any "YES" answers: _____

Any **family history** of the above conditions: _____

Allergies to medications? Yes No If yes, please list/explain: _____

Please list all **medications** you are currently taking: _____

Do you wear glasses or contacts? Yes No Brand or Type _____

Do you drink alcohol? Yes No If "Yes", drinks per day _____

Do you smoke? Yes No Former Smoker? Yes No

Do you use illicit drugs? Yes No If "Yes", what _____