PATIENT_____ **DATE**_____

MEDICAL HISTORY

◈ **Please indicate any EYE CONDITIONS you have ever had or are currently being treated for:**

☐ GLAUCOMA ☐ CATARACTS ☐ MACULAR DEGENERATION ☐ EYE INJURY

☐ RETINAL DETACHMENT OR DISEASE ☐ "LAZY" OR WANDERING EYE (please specify_____)

☐ DIABETIC EYE DISEASE ☐ DRY EYE ☐ OTHER_____

◈ **Do you wear GLASSES?** ☐ YES ☐ NO LENS STYLE: ☐ DISTANCE ONLY ☐ READING ONLY

☐ LINED BIFOCAL ☐ NO-LINE PROGRESSIVE

◈ **Do you wear CONTACTS?** ☐ YES ☐ NO BRAND:_____

☐ 2 WEEK DISPOSABLE ☐ MONTHLY DISPOSABLE ☐ CONTINUOUS WEAR (NIGHT AND DAY)

☐ NON-DISPOSABLE DAILY WEAR SOFT CONTACT ☐ GAS PERMEABLE

◈ **Please indicate *FAMILY* HISTORY of any medical conditions, including eye diseases, and *WHO* was affected:**

☐ GLAUCOMA _____ ☐ CATARACTS _____ ☐ MACULAR DEGENERATION _____

☐ RETINAL DETACHMENT OR DISEASE _____ ☐ BLINDNESS _____

☐ "LAZY" OR WANDERING EYE (please specify)_____

☐ DIABETES _____ ☐ CANCER_____ ☐ HEART DISEASE _____

☐ HIGH BLOOD PRESSURE _____ ☐ INCREASED CHOLESTEROL _____

☐ KIDNEY DISEASE _____ ☐ STROKE _____ ☐ PULMONARY DISEASE _____

☐ ARTHRITIS _____ ☐ THYROID DISEASE _____

☐ AUTOIMMUNE DISORDER (please specify disease, also)_____

☐ OTHER_____

◈ **MEDICAL HISTORY:** Prior Hospitalization? Yes / No Details:_____

Previous Anesthesia? Yes / No Local / General

◈ **SOCIAL HISTORY: Tobacco Status:** ☐ Current Every Day Smoker ☐ Current Occasional Smoker

☐ Former Smoker ☐ Never a Smoker

Alcohol Status: ☐ 3 or less per week ☐ 4 or more per week

☐ Daily ☐ Social Only ☐ Never

◈ **Please indicate any MEDICAL CONDITIONS you have ever had or are currently being treated for:**

Cardiovascular Condition:

☐ ATRIAL FIBRILLATION ☐ CONGESTIVE HEART FAILURE ☐ CORONARY ARTERY DISEASE

☐ GIANT CELL ARTERITIS ☐ HEART ATTACK ☐ HEART FAILURE ☐ HIGH BLOOD PRESSURE

☐ INCREASED CHOLESTEROL ☐ MITRAL VALVE PROLAPSE ☐ PERIPHERAL VASCULAR DISEASE

☐ STROKE ☐ TIA ☐ TEMPORAL ARTERITIS ☐ OTHER_____

Respiratory Condition:

☐ ALLERGIC RHINITIS ☐ ASTHMA ☐ COPD ☐ CHRONIC SINUSITIS ☐ EMPHYSEMA ☐ LUNG CANCER

☐ SLEEP APNEA CPAP? YES / NO ☐ OTHER_____

Gastrointestinal Condition:

☐ CELIAC SPRUE ☐ CIRRHOSIS ☐ COLITIS ☐ COLON CANCER ☐ CROHN'S DISEASE

☐ GASTROINTESTINAL REFLUX ☐ HEPATITIS ☐ IRRITABLE BOWEL SYNDROME

☐ OTHER_____

Genitourinary Condition:

☐ BENIGN PROSTATE HYPERTROPHY ☐ BREAST CANCER ☐ PROSTATE CANCER ☐ RENAL FAILURE

☐ OTHER_____

Musculoskeletal Condition:

☐ ARTHRITIS ☐ FIBROMYALGIA ☐ LUPUS ☐ POLYMYALGIA RHEUMATICA ☐ RHEUMATOID ARTHRITIS

☐ SJOGREN'S SYNDROME ☐ OTHER_____

Skin Condition:

☐ ECZEMA ☐ PSORIASIS ☐ ROSACEA ☐ SKIN CANCER ☐ OTHER_____

Neurological Condition:

☐ ALZHEIMER'S DISEASE ☐ CHRONIC HEADACHES ☐ DEMENTIA ☐ EPILEPSY ☐ ESSENTIAL TREMOR

☐ MIGRAINES ☐ MULTIPLE SCLEROSIS ☐ PARKINSON'S DISEASE ☐ RESTLESS LEG SYNDROME

☐ OTHER_____

Endocrine Condition:

☐ DIABETES: NON-INSULIN / INSULIN ☐ GOUT ☐ GRAVE'S DISEASE

☐ THYROID DISEASE: HYPER / HYPO ☐ OTHER_____

Hematologic / Lymphatic Condition:

☐ ANEMIA ☐ FACTOR V LEIDEN ☐ LEUKEMIA ☐ LYMPHOMA ☐ OTHER_____

◈ **Please list any EYE SURGERY OR LASER TREATMENT you have had, which eye, year procedure was performed, and who the physician was who performed it:**

_____

_____

◈ **Do you take *ANY* MEDICATIONS? (Including for your eyes)** ☐ YES ☐ NO

IF YES, PLEASE LIST: (PLEASE INCLUDE DOSAGE IF YOU ARE ABLE)

_____

_____

_____

_____

_____

_____

_____

_____

◈ **Are there *ANY* MEDICATIONS you are or have been ALLERGIC TO OR CANNOT TAKE?** ☐ YES ☐ NO

IF YES, PLEASE LIST: _____

_____

◈ **Who is your PRIMARY CARE PHYSICIAN?**

_____