Name _____ Date of Birth (M/D/Y): _____/_____/_____

Ocular and General Medical History *Please indicate the year in which you were diagnosed*

	Year		*Year*		*Year*
☐ Trauma to Eye/Face	____	☐ Cataracts	____	☐ Kidney Problems	____
☐ Dry Eye	____	☐ Hypertension	____	☐ HIV Positive	____
☐ Diabetic Eye Disease	____	☐ Diabetes	____	☐ Cancer	____
☐ Iritis	____	☐ Heart Attack	____	☐ Stroke	____
☐ Macular Degeneration	____	☐ High Cholesterol	____	☐ Arthritis	____
☐ Glaucoma	____	☐ Thyroid Disease	____	☐ Autoimmune Dis.	____
☐ Migraine Headaches	____	☐ Lung Problems	____	☐ Seasonal Allergies	____

Other Medical or Ocular Problems Not Listed: _____
_____

Previous Eye Surgeries (include which eye): _____
_____

Eye Medications (please include which eye): _____
_____

Previous Surgeries (other than eye): _____
_____

Drug Allergies: _____

Social History

Smoking: How many packs a day do you smoke? _____ For how many years? ____ ☐ I Quit
Alcohol: How many alcoholic drinks do you consume in a week? _____
Drug Use: Do you have current use or a history of use of illegal drugs? _____

Family History *Does anyone in your family have any of the following conditions. Who?*

☐ Iritis	_____	☐ Heart Disease	_____
☐ Glaucoma	_____	☐ Stroke	_____
☐ Lazy Eye	_____	☐ Cancer	_____
☐ Retinal Detachment	_____	☐ Diabetes	_____

Medication History

Please list any current medications you are taking:

Medication	Dose	Frequency

The Information above is accurate to the best of my knowledge.

Signature/Guardian Signature: X _____ Date: _____