NAME:_____DATE:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR MEDICAL STATUS AND HISTORY:

1. Have you ever been treated for any chronic medical conditions (diabetes, high blood pressure, heart disease, heart attack, arthritis, asthma, emphysema, other)? YES NO If YES, please explain:_____
   _____
   _____
2. Have you ever had any eye disease (glaucoma, cataract, wandering or "lazy" eye, retinal detachment, other)? YES NO If YES, please explain:_____
   _____
   _____
3. Have you ever had any surgery? YES NO If YES, please provide date and reason: ___
   _____
   _____
4. Have you ever been hospitalized? YES NO If YES, please provide date and reason: ___
   _____
   _____
5. Are you pregnant? YES NO
6. Do you have AIDS, Hepatitis or other infectious disease? YES NO _____
7. Do you take any medications? YES NO If YES, please list with dosage: _____
   _____
   _____
8. **DO YOU HAVE ANY DRUG OR OTHER ALLERGIES?** YES NO If YES, please list:
   _____
   _____

REVIEW OF SYSTEMS

Have you had or currently have any of the following problems:			If YES, please explain
Chronic fevers, unexpected weight loss/gain, fatigue:	Y	N	_____
Ear/nose/throat problems (hearing loss, sinus problems, sore throat):	Y	N	_____
Heart problems (chest pain, irregular heart beat, high blood pressure):	Y	N	_____
Respiratory problems (shortness of breath, asthma, emphysema):	Y	N	_____
Gastrointestinal problems (ulcer, heartburn, diarrhea):	Y	N	_____
Urinary problems (pain or discomfort, blood in urine):	Y	N	_____
Skin problems (rashes):	Y	N	_____
Musculoskeletal problems (arthritis, muscle aches, swollen joints):	Y	N	_____
Neurologic problems (numbness, weakness, headaches, paralysis):	Y	N	_____
Psychiatric problems (depression, anxiety):	Y	N	_____

FAMILY AND SOCIAL HISTORY

Do any medical conditions or eye diseases run in your family (diabetes, high blood pressure, cancer, glaucoma, macular degeneration)? YES NO If YES, please explain: _____
_____

Do you use tobacco products? If YES, how much? _____

Do you drink alcohol: If YES, how much? _____

Reviewed:

Date_____Tech_____ M.D._____Date_____Tech_____M.D._____
Date_____Tech_____ M.D._____Date_____Tech_____M.D._____
Date_____Tech_____ M.D._____Date_____Tech_____M.D._____
Date_____Tech_____ M.D._____Date_____Tech_____M.D._____
Date_____Tech_____ M.D._____Date_____Tech_____M.D._____