Name:_____ **Date:**_____

EYE HISTORY

Have you or a family member experienced or been treated for any of the following? Please circle all that apply. (S-sibling, P-parent, G-grandparent)

YOU			FAMILY			
Yes	No	Cataracts	S	P	G	No
Yes	No	Crossed/Lazy Eye	S	P	G	No
Yes	No	Glaucoma	S	P	G	No
Yes	No	Macular Degeneration	S	P	G	No
Yes	No	Retinal Detachment	S	P	G	No

Are you experiencing any of the following? Please circle all that apply.

Blurry Vision	Burning	Discharge	Double Vision	Dryness
Excess tearing	Eye Infection	Eye Pain	Floaters	Halos
Headaches	Itching of Eyes	Light Flashes	Light Sensitivity	Redness
Sandy/Gritty Feeling	List Any Previous Eye Injuries or Surgeries_____			

MEDICAL HISTORY

Have you or a family member experienced or been treated for any of the following? Please describe the type of condition.

YOU				FAMILY				
Yes	No_____	Allergies		S	P	G	No	_____
Yes	No_____	Arthritis		S	P	G	No	_____
Yes	No_____	Asthma		S	P	G	No	_____
Yes	No_____	Blood/Lymph Disorders		S	P	G	No	_____
Yes	No_____	Cancer		S	P	G	No	_____
Yes	No_____	Diabetes		S	P	G	No	_____
Yes	No_____	Gastrointestinal Disorders		S	P	G	No	_____
Yes	No_____	Heart Disease		S	P	G	No	_____
Yes	No_____	High Blood Pressure		S	P	G	No	_____
Yes	No_____	High Cholesterol		S	P	G	No	_____
Yes	No_____	Neurological Conditions		S	P	G	No	_____
Yes	No_____	Psychiatric Conditions		S	P	G	No	_____
Yes	No_____	Skin Conditions		S	P	G	No	_____
Yes	No_____	Thyroid Disorders		S	P	G	No	_____

Height_____ Weight_____ Females: Are you pregnant or nursing? Yes___ No___

Smoking Status: Never___ Former____ Current___ If current, approx. number per day_____

Name of Primary Care Physician_____

Please list all Medications, prescription and over-the-counter with dosages, if known:_____

_____

_____

Please list any Allergies to Drug Medications:_____

_____