Medical History (page 1)

Name: _____

Do you now have or have you had in the past:

	NO	YES
Cataract		
History of glaucoma		
Diabetic Retinopathy		
Macular Degeneration		
Amblyopia/Lazy eye		
Eye trauma		
	NO	YES
Uveitis/Iritis (Inflammation)		
Eye muscle imbalance		
Facial/Bell's Palsy		
Eyelid Tumor		
Drooping Eyelids		
Eye Tumor		
Facial Pain		
Conjunctivits		
	NO	YES
Double Vision		
Dry eye		
Tear duct disorder		
Retinal Detachment		
Retinal hole/tear		
Posterior Vitreous Detach		
	NO	YES
Night Blindness		
Blindness		
Color Blindness		
Eye Socket Problems		
Optic Neuritis		
Optic Neuropathy		
	NO	YES
LASIK-refractive surgery		
Facial plastic surgery		
Corneal Transplant		
Glasses		
Contact Lenses		

Do you now have or have you had in the past:

	NO	YES
Diabetes		
High Blood Pressure		
Heart Disease		
Elevated Cholesterol		
Graves disease		
Carotid Artery Disease		
Temporal Arteritis		
Premature Birth		
Birth Trauma		
Genetic Defects		
	NO	YES
Stroke		
Cancer		
HIV/AIDS		
Hepatitis		
Alcoholism		
Asthma		
Lyme Disease		
Arthrtis		
Gall Bladder Disease		
	NO	YES
Sickle Cell Anemia/Trait		
Ulcerative Colitis		
Emotional Disorder		
Skin Condition		
Lupus		
Thyroid Disease		
Organ Transplant		
Parkinsons Disease		
Multiple Sclerosis		
	NO	YES
Renal (Kidney) Disease/Dialysis		
Nutritional deficiency		
Decreased sense of smell		
Decreased sense of taste		

Other medical problems not listed above

Medical History (page 2)

Name: _____

Eye Surgical Procedures (list)	Date	Surgeon/Facility

Other Surgical Procedures (list)	Date	Surgeon/Facility

Family History - Do you have any close relatives with any of the following problems?

	NO	YES
Macular Degeneraton		
Cataract		
Glaucoma		
Ocular Cancer		
Retinal Tear/Detachment		
Blindness		
Other ocular disease		

	NO	YES
Diabetes		
Heart Disease		
High Blood Pressure		
Stroke		
Sickle Cell Anemia/Trait		
Migraines		

Eye Medications (Drops)	Dosage

Medications	Dosage

Allergies (list medical allergies)