Ocular History

Have you ever been diagnosed with the following?	Yes	No
Glaucoma		
Cataracts		
Macular Degeneration		
Amblyopia (Lazy Eye)		
Retinal Issues		
Keratoconus		

General Medical History

Do you have any of the following?	Yes	No
Hearing Loss		
Sinusitis		
Dry Mouth		
Multiple Sclerosis		
Epilepsy		
Cerebral Palsy		
Tumors		
Migraines		
Alzheimer's/ Dementia		
Depression		
Anxiety		
Bipolar		
High Blood Pressure		
Stroke		
High Cholesterol		
Heart Disease		
Vascular Disease		
Congestive Heart Failure		
Asthma		
COPD		
Emphysema		
Sleep Apnea		
Crohn's		
Colitis		
Celiac Disease		
Ulcers		
Kidney Disease		
Prostate Disease/Cancer		
Herpes		
Chlamydia		
Arthiritis		
Fibromyalgia		
Muscular Dystrophy		
Rosacea		
Melanoma		
Eczema		
Shingles		
Diabetes: What Type_____		
Thyroid Dysfunction		
Hormonal Dysfunction		

Have you had any EYE surgeries? Please list.

Date	Type of Eye Surgery

Family History

	Yes	No	If yes, what is their relationship to you?
Glaucoma			
Cataracts			
Macular Degeneration			
Amblyopia (lazy Eye)			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney Disease			

	Yes	No
Are you pregnant or nursing? Due Date_____		
Do you drink alcohol?		
Do you smoke?		

Please list all allergies.

_____

_____

_____

Current Medications

Name of Medication	Dosage