Name: _____ DOB: _____

Primary Care Doctor: _____

Please answer the following questions to the best of your ability.

MEDICAL/SURGICAL HISTORY

Do you or have you had any serious medical problems?.....Yes [ ] No [ ]
(ie: heart, lung, kidney disease, high blood pressure, diabetes, cancer)
If yes, please describe

_____

_____

Do you have diabetes?.....Yes [ ] No [ ]
If yes…
Type I [ ] Type II [ ]
How long have you had diabetes? _____
What was your last blood sugar reading? _____ Hemoglobin A1c? _____

Have you ever had any major surgeries?.....Yes [ ] No [ ]
If yes, please describe

_____

_____

Does your vision make daily activities difficult?.....Yes [ ] No [ ]
If yes, please describe

_____

_____

SOCIAL HISTORY (Please circle one)
Smoking Status.....Never [ ] Former [ ] Current [ ]

Alcohol Use.....Never [ ] Rarely [ ] Socially [ ] Frequently [ ]

Recreational Drug Use.....Yes [ ] No [ ]
If yes, please describe

_____

Name: _____ DOB: _____

FAMILY HISTORY

Do any eye diseases run in your family?.....Yes [ ] No [ ]
(ie: glaucoma, cataracts, macular degeneration, retinal detachment)
If yes, please describe

_____

_____

Do any significant medical diseases run in your family?.....Yes [ ] No [ ]
(ie: heart, lung, or kidney disease, high blood pressure, cancer)
If yes, please describe

_____

_____

Please list **any <u>EYE</u>** medications that you are taking (eye drops, vitamins, etc.), including any over-the-counter products.

Name of Med	Amount	Times per Day	Which Eye

Please list any medication allergies:

_____

_____

Do you have any specific concerns you would like to address today?

_____

_____