PATIENT MEDICAL/VISION INFORMATION

NAME _____ **DOB** _____ **DATE** _____

Do you have or have you ever had the following eye conditions? If so, please explain.						
CATARACTS	Y / N		ITCHING	Y / N	
MACULAR DEGENERATION	Y / N		TEARING	Y / N	
GLAUCOMA	Y / N		DISCHARGE	Y / N	
DIABETES	Y / N		BLURRED VISION	Y / N	
DIABETIC RETINOPATHY	Y / N		EYESTRAIN	Y / N	
DRY EYES	Y / N		EYE PAIN	Y / N	
FREQUENT EYE INFECTIONS	Y / N		SEVERE SENSITIVITY TO LIGHTS	Y / N	
FLASHES/FLOATERS	Y / N		HEADACHES	Y / N	
IRITIS OR UVEITIS	Y / N		POOR NIGHT VISION	Y / N	
RETINAL DISEASE, TEARS, OR DETACHMENT	Y / N		BOTHERSOME NIGHT GLARE	Y / N	
REDNESS	Y / N		DOUBLE VISION	Y / N	
BURNING	Y / N		BLINDNESS	Y / N	
OTHER					

Do you have or have you ever had the following medical conditions? Please circle the condition and explain if needed.
Developmental Delays / Cancer / Fatique Syndrome
Hearing Loss / Sinusitis / Dry Mouth / Laryngitis
Multiple Sclerosis / Epilepsy / Cerebral Palsy / Tumor / Stroke / CVA / Migraine / Autism Spectrum Disorder
Depression / Attention Deficit Disorder / Anxiety Disorder /Bipolar Disorder
Hypertension / Stroke / Heart Disease / Vascular Diesease / Congestive Heart Failure
Cigarette Smoker / Asthma / Bronchitis / Emphysema / COPD / Sleep Apnea
Crohns / Colitis / Celiac Disease / Ulcer / Acid Reflux
Kidney Disease / Prostate Disease or Cancer / STD-Herpetic / Chlamydia / Benign Prostate Hypertrophy / Pregnant / Nursing
Arthritis / Osteoarthritis / Fibromyalgia / Muscular Dystrophy / Ankylosing Spondylitis / Osteoporosis / Gout
Eczema / Rosacea / Psoriasis / Herpes Simplex / Cold Sores / Herpes Zoster / Shingles
Type 1 or 2 Diabetes Thyroid Dysfunction / Hormonal Dysfunction
Anemia / Blood Loss / Ulcer / High Cholesterol
Drug or Environmental Allergies / Rheumatoid Arthritis / Lupus / Sjogrens
OTHER

PLEASE LIST ALL MEDICATIONS OF ANY KIND THAT YOU ARE CURRENTLY TAKING ALONG WITH THE DOSAGE, OR ATTACH A MEDICATION LIST_____

_____

PLEASE LIST ANY ENVIRONMENTAL OR DRUG ALLERGIES YOU MAY HAVE._____

_____

Is there any family history of the following? If so what relation. M-Mother F-Father S-Siblings GP- Grandparents							
BLINDNESS	Y	N		CROSSED EYES	Y	N	
CATARACTS	Y	N		LAZY EYE/AMBLYOPIA	Y	N	
GLAUCOMA	Y	N		HIGH BLOOD PRESSURE	Y	N	
MACULAR DEGENERATION	Y	N		DIABETES	Y	N	
RETINAL DISEASE	Y	N		OTHER			

Health Habits: (This information is kept strictly confidential) Do you smoke or use tobacco products? (yes or no) Do you drink alcohol? (yes or no) Do you use any kind of illegal drugs? (yes or no) Have you ever been infected with Gonorrhea, Hepatitis, HIV or Syphillis? (yes or no) _____

PATIENT OR GUARDIAN SIGNATURE:_____ DATE:_____