Name: ______________________________ Date of Birth: ________________

Primary Care Physician: ________________ Referring Physician: ________________
Previous Eye Doctor: ________________

Past Ocular History:

Glasses	Y/N
Contacts Lenses	Y/N
Type/Frequency: ____________________	
Cataracts	Y/N
Glaucoma	Y/N
Macular Degeneration	Y/N
Diabetic Eye Disease	Y/N
Strabismus	Y/N
Amblyopia	Y/N
Corneal Disease	Y/N
Other	Y/N

Past Ocular Surgery/Laser:

Procedure		Date
____________________	Right/Left	____________
____________________	Right/Left	____________
____________________	Right/Left	____________
____________________	Right/Left	____________
____________________	Right/Left	____________
____________________	Right/Left	____________
____________________	Right/Left	____________

Family Eye History:

		Relation
Cataracts	Y/N	____________
Glaucoma	Y/N	____________
Macular Degeneration	Y/N	____________
Retinal Disease	Y/N	____________
Strabismus	Y/N	____________
Amblyopia	Y/N	____________
Corneal Disease	Y/N	____________
Other	Y/N	____________
		____________
		____________

Personal Past Medical History:

		Type/Duration
Diabetes	Y/N	If yes type 1 or 2
Insulin Dependent Y/N		
Hypertension	Y/N	____________________
Heart Disease	Y/N	____________________
Cancer	Y/N	____________________
Lung Disease	Y/N	____________________
Thyroid Dz	Y/N	____________________
Arthritis	Y/N	____________________
Pregnant	Y/N	____________________
Nursing	Y/N	____________________
Other	Y/N	____________________

Medications: **Dose/Frequency**

Medications	Dose/Frequency
____________________	____________
____________________	____________
____________________	____________
____________________	____________
____________________	____________
____________________	____________
____________________	____________
____________________	____________
____________________	____________
____________________	____________

Past Surgical History: **Date**

Past Surgical History	Date
____________________	____________
____________________	____________
____________________	____________
____________________	____________
____________________	____________
____________________	____________

Allergies	**Reaction**
____________________	____________
____________________	____________
____________________	____________
____________________	____________
____________________	____________

Social History:

Occupation__________________ Retired Y/N
Single Married Widowed Divorced Sig. Other
Alcohol: Y/N ______ Drinks/ day week mos year
Tobacco: Y/N/Quit-When_______ Packs/Day____Years ______