NAME: DATE: CHART #:

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY.

OCULAR HISTORY: DO YOU OR HAVE YOU HAD?

CATARACTS_____ SURGERY_____

GLAUCOMA_____ OTHER_____

RETINAL DISEASE_____

MEDICAL HISTORY: DO YOU OR HAVE YOU HAD?

DIABETES_____ THYROID PROBLEM_____

HEART ATTACK_____ CANCER_____

HIGH BLOOD PRESSURE_____ ARTHRITIS_____

ASTHMA_____ SKIN PROBLEMS_____

MIGRAINES_____ HIGH CHOLESTEROL_____

SURGERY_____ OTHER_____

FAMILY HISTORY OF EYE DISEASE_____

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

_____

_____

_____

ARE YOU ALLERGIC TO ANYTHING (INCLUDING MEDICATIONS) ?

_____

_____

_____

_____

PATIENT SIGNATURE DATE