Ocular History (Please circle any eye conditions that you had/have)

Amblyopia (lazy eye)	Diabetic Retinopathy	Glaucoma	Other:
Dry eyes/blepharitis	Diplopia (double vision)	Macular Degeneration	
Cataracts	Floaters		

Past Ocular Surgeries / Procedures (Please circle)

No prior eye surgeries	Cataract surgery R L	LASIK	Other:
Eyelid surgery	Corneal transplant	Retinal surgery	
YAG (laser after cat surgery)	Glaucoma Surgery/Laser	RK incisions	

Current Eye Medications:

No eye meds	Please list:

Medical History (Please circle any systemic illness you had/have)

Anemia	Diabetes Meds/ Insulin	High cholesterol	Trauma:
Asthma	Graves Disease	History of stroke	
Atrial Fibrillation	Headache	Migraine	Other:
Cancer:	Heart Disease	Multiple Sclerosis	
Emphysema	High blood pressure	Rheumatoid Arthritis	

General surgeries (Please circle any surgeries you have had)

No prior surgeries	Coronary Artery Bypass	Hip replacement	Pacemaker implant
Aortic valve surgery	Gallbladder	Hysterectomy	Prostate surgery
Appendectomy	GI surgery	Kidney/Pancreas transplant	Status post angioplasty
Back surgery	Heart transplant	Knee replacement	Thyroidectomy
Carotid surgery	Heart Stents	Mastectomy	Tonsillectomy
Colectomy/Colon surgery	Hernia repair	Mitral valve surgery	Other:

Allergies (Please list any allergies and your reaction to the allergen)

None	Penicillin Y N Reaction:	Other:
	Latex Y N Reaction:	Reaction:
	Sulfa Y N Reaction:	

Family History (Please circle if your (M)other, (F)ather or (S)ibling has any of these conditions)

Adopted	Blindness M F S	Retinitis Pigmentosa M F S
Diabetes M F S	Glaucoma M F S	Macular Degeneration M F S

Social

Alcohol Use		**Smoking Status (Frequency /Type)**	
No alcohol use	Social	Never smoker	Cigarettes
Quit/Former alcoholic	1-2 drinks per day	Former smoker	Controlled substances
Occasional	3-4 drinks per day	Daily smoker	Chewing tobacco
		Occasional smoker	Other:
Currently drives: Y N			

Name: _____ Primary Care Doctor: _____

Pharmacy you use for medications: _____ Intersection:_____Phone: _____