Date _____ Name _____ Date of Birth _____

	You		Family -- if yes, who?		
	Yes	No	Yes	No	
Eye Surgery	☐	☐	☐	☐	_____
Eye Injury	☐	☐	☐	☐	_____
Glaucoma	☐	☐	☐	☐	_____
Cataracts	☐	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	☐	_____
Retinal Detachment	☐	☐	☐	☐	_____
Lazy Eye	☐	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	☐	_____

Do you or anyone in your family have any of the following medical problems?

	You		Family -- if yes, who?		
	Yes	No	Yes	No	
Diabetes	☐	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	☐	_____
Heart Disease	☐	☐	☐	☐	_____
Asthma	☐	☐	☐	☐	_____
Emphysema	☐	☐	☐	☐	_____
Cancer	☐	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	☐	_____
Neurological Disorder	☐	☐	☐	☐	_____
Stroke in the past	☐	☐	☐	☐	_____
AIDS/HIV	☐	☐	☐	☐	_____
Psychiatric	☐	☐	☐	☐	_____
_____	☐	☐	☐	☐	_____

Do you smoke? _____ If so, # packs per day? _____ Do you drink alcohol? _____ If so, how many drinks per day? _____ Do you use recreational drugs? _____ If so, what type? _____

List all major illnesses and injuries _____

_____

List any surgeries you have in the past _____

_____

List all medications you are currently taking *(prescription and over the counter)*

1. _____ 3. _____ 5. _____ 7. _____
2. _____ 4. _____ 6. _____ 8. _____

List any medication you are allergic to: _____

_____

Do you have any problems with the following systems of your body? *If yes, please explain.*

	Yes	No		Date Reviewed				
Head/Neck	☐	☐	_____					
Ears, Nose, Mouth, Throat	☐	☐	_____					
Respiratory (lungs, etc.)	☐	☐	_____					
Gastrointestinal (stomach, intestines)	☐	☐	_____					
Muscles	☐	☐	_____					
Bones	☐	☐	_____					
Skin	☐	☐	_____					
Glands	☐	☐	_____					
Blood / Lymph System	☐	☐	_____					
Allergies	☐	☐	_____					
				_____	_____	_____	_____	_____
				initials	*initials*	*initials*	*initials*	*initials*

Signature _____ Initials _____