

Medical History

Name: _____

Date: _____

Do you have any allergies to medications? No Yes If yes, explain _____

List any medications you take (including oral contraceptives over the counter medications and home remedies):

Medical Information

Do you currently have any problems in the following areas? (Circle yes or no for each condition)

DIABETES	YES	NO	ELEVATED CHOLESTEROL	YES	NO
HIGH BLOOD PRESSURE	YES	NO	ELEVATED TRIGLYCERIDES	YES	NO
HEART DISEASE	YES	NO	HEADACHES	YES	NO
ARTHRITIS	YES	NO	EYE SURGERY	YES	NO
THYROID DISEASE	YES	NO	EYE INJURIES	YES	NO
ASTHMA	YES	NO	GLAUCOMA	YES	NO
RHEUMATOID ARTHRITIS	YES	NO	CATARACT	YES	NO
ALLERGIES/HAY FEVER	YES	NO	MACULAR DEGENERATION	YES	NO

If you answered yes to any of the above or have a condition not listed, please explain

Family History

Please note any **family history** for the following conditions? (Circle yes or no for each condition)

DISEASE/CONDITION	YES	NO	If History in family list relationship to you
DIABETES	YES	NO	_____
HIGH BLOOD PRESSURE	YES	NO	_____
GLAUCOMA	YES	NO	_____
CATARACT	YES	NO	_____
MACULAR DEGENERATION	YES	NO	_____
HEART DISEASE	YES	NO	_____

Social History

This information is kept strictly confidential. However you may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss my Social History with the doctor

Do you drive? No Yes if yes, do you have visual difficulty when driving? No Yes

If yes, please describe _____

Do you use tobacco products? No Yes If yes how much and for how long _____

Do you drink alcohol? No Yes If yes how much _____