OCULAR HISTORY

Date of Last Eye Exam: / / **Last Eye Exam Location**:

Eye Diseases or Eye Surgeries (include dates):

❏ NONE

MEDICAL HISTORY

Pharmacy (Name and Location):

Medications, Over the Counter, Supplements (with dosage):

1. ______________________ 8. ______________________
2. ______________________ 9. ______________________
3. ______________________ 10. ______________________
4. ______________________ 11. ______________________
5. ______________________ 12. ______________________
6. ______________________ 13. ______________________
7. ______________________ 14. ______________________

Allergies with Reactions (list all):

❏ NONE

Medical Problems (check any/and all that apply):

- ❏ ADD/ ADHD
- ❏ Anemia
- ❏ Anxiety
- ❏ Arthritis (type)______
- ❏ Asthma
- ❏ Bells' Palsy
- ❏ Cancer (type) _________
- ❏ Colitis
- ❏ COPD
- ❏ Crohn's Disease
- ❏ Diabetes (Insulin)
- ❏ Diabetes (Non-Insulin)
- ❏ Depression
- ❏ Epilepsy
- ❏ Fibromyalgia
- ❏ High Cholesterol
- ❏ HIV/ AIDS/ STD
- ❏ Hormonal Dysfunction
- ❏ Neurofibromatosis
- ❏ Pregnant (weeks)________
- ❏ Rosacea
- ❏ Heart Disease
- ❏ Muscular Dystrophy
- ❏ Lupus
- ❏ Multiple Sclerosis
- ❏ Sleep Apnea
- ❏ Thyroid Problems
- ❏ Other_______________

Height: _______ft _______inches.
Weight: __________lbs.

Tobacco Use:
- ❏ YES
- ❏ NO
- ❏ FORMER

Alcohol Use:
- ❏ NONE
- ❏ SOCIAL
- ❏ MODERATE
- ❏ EXCESSIVE

Drug Use:
- ❏ YES
- ❏ NO
- ❏ FORMER

Medical Surgeries (include date and type):

❏ NONE

FAMILY HISTORY

Conditions: (check all that apply, and state the family relationship)

- ❏ Cataracts____________
- ❏ Diabetes____________
- ❏ Glaucoma___________
- ❏ Heart Disease________
- ❏ High Blood Pressure___
- ❏ Macular Degeneration____
- ❏ Retinal Detachment_______
- ❏ Other____________