

PAST HISTORY (MEDICAL)

List any medications (other than eyedrops) that you are currently using: _____

List all major illnesses: Diabetes _____ Hypertension _____

Other: _____

List any major surgical procedures: _____

Do you have any medication allergies? [] NO [] YES Penicillin Sulfa

List other medication allergies: _____

FAMILY HISTORY

	YES	NO	EXPLANATION/RELATIONSHIP
OCULAR			
Blindness	[]	[]	_____
Cataract	[]	[]	_____
Glaucoma	[]	[]	_____
Macular degeneration	[]	[]	_____
Retinal detachment	[]	[]	_____
MEDICAL			
Diabetes	[]	[]	_____
Arthritis, lupus, etc.	[]	[]	_____
Other (list)	[]	[]	_____

SOCIAL HISTORY

	YES	NO	EXPLANATION
OCULAR			
Have you ever tried to wear contacts?	[]	[]	_____
Did you have problems with contacts?	[]	[]	_____
Vision causes problems with:			
<input type="checkbox"/> Driving			<input type="checkbox"/> Reading
<input type="checkbox"/> Night vision			<input type="checkbox"/> Sports/Outdoor activities
GENERAL			
Do you drink alcohol?	[]	[]	How much per day? _____
Do you smoke?	[]	[]	
Have you ever had a blood transfusion?	[]	[]	
Have you ever had contact with a person who had a sexually transmitted disease?	[]	[]	

Patient's signature: _____ Date: _____

History reviewed [] No changes [] Additions as noted

Physician's signature: _____ Date: _____