

Patient _____ Date _____ Occupation _____

DOB _____ AGE _____ SEX: MALE FEMALE RACE: AFRICAN AMERICAN HISPANIC ASIAN CAUCASIAN OTHER

Drug allergies/sensitivity/intolerances _____

Do you have any of the following diagnosis?

Mark Appropriate box for **BLOOD RELATIVES** Column
F – Father **M** – Mother **B** – Brother **S** – Sister

	PERSONAL		EXPLAIN	BLOOD RELATIVES
	YES	NO		
Asthma / Emphysema				
Heart Attack / Arrhythmia				
High Blood Pressure				
Arthritis				
Eczema / Psoriasis / Rosacea				
Migraines				
Stroke				
Ulcers / Crohn's				
Thyroid Disease				
Diabetes-Insulin / Non-Insulin				
High Cholesterol				
Leukemia / HIV / Hepatitis				
Sjogren's / Lupus				
Cancer				
Any other medical diseases?				
Surgeries - other than eyes, please list				

Do you smoke? Yes No If YES, how much? packs/day **Do you consume alcohol:** Yes No If YES, how often?

Do you exercise? none / occasional / often **Driving:** Yes No

Are you having or have you ever had any of the following?

	PERSONAL		DATE	BLOOD RELATIVE
	YES	NO		
Eye Injury				
Double Vision				
Flashing Lights / Floaters				
Decreased / Blurred Vision				
Halos / Foggy Vision				
Cataracts				
Glaucoma				
Lazy eye - poor childhood vision, patched as a child				
Retinal Detachment				
Diabetic Retinopathy				
Macular Degeneration				
Blepharitis				
Other Eye Diseases				
Ocular Surgery/Notes:				

