

YOUR MEDICAL HISTORY

(PLEASE CHECK ALL THAT APPLY)

- | ○ CONDITION | FIRST DIAGNOSED |
|----------------------------------|-----------------|
| ○ Diabetes | _____ |
| ○ High Blood Pressure | _____ |
| ○ High Cholesterol | _____ |
| ○ Heart Condition | _____ |
| ○ Stroke | _____ |
| ○ Thyroid Disease | _____ |
| ○ Anemia | _____ |
| ○ Respiratory Problems | _____ |
| ○ Gastrointestinal Problems | _____ |
| ○ Urinary Problems | _____ |
| ○ Skin Problems | _____ |
| ○ Arthritis,muscle/joint pain | _____ |
| ○ Tuberculosis | _____ |
| ○ Liver Disease/Hepatitis | _____ |
| ○ Kidney Disease/Stones | _____ |
| ○ Cancer or tumor | _____ |
| ○ Seizures | _____ |
| ○ Varicose Veins/Leg Blood Clots | _____ |
| ○ HIV,AIDS,Other Blood Disorders | _____ |
| ○ Ear/Nose/Throat | _____ |
| ○ Depression/Anxiety | _____ |
| ○ Neurological Problems | _____ |

OCULAR HEALTH HISTORY

(YOU OR IMMEDIATE FAMILY)

Cataracts_____

Glaucoma_____

Macular Degeneration_____

Color Blindness_____

Retinal Diseases_____

Blindness_____

Unexplained Vision Loss_____

Lazy Eye_____

SOCIAL HISTORY

Do you smoke? Yes___no___

Do you drink alcohol?yes___no___

current weight_____height_____

CURRENT MEDICATIONS

AMOUNT

TIMES DAILY

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

ALLERGIES

Medications:_____

Environmental:_____

I certify that I have answered the above information to the best of my knowledge.

X _____
Signature of patient

