Name_____ **Date**_____
Primary Care Doctor_____ **Date of Birth**_____
Reviewed By _____ On_____ **Reviewed By** _____ On_____
Reviewed By _____ On_____ **Reviewed By** _____ On _____

Please List ALL

Drug Allergy(ies)_____
Latex Allergy Rash _____ Severe _____ Other Explain _____
Food Allergy(ies) _____
Medications (including Aspirin, Hormones and Herbals) Use back of sheet if necessary
_____
_____

Eye Drops (Prescription or Non-Prescription) _____
Do you work? No_____ Yes, how many hours per week? _____
Do you smoke currently? _____ Did you smoke previously? _____ If so how long ago? _____

Circle ALL that Apply

Personal History
High Blood Pressure Stroke/TIA Heart Attack
Congestive Heart Failure Asthma Diabetes
Emphysema Retinal Detachment R or L
Migraines Glaucoma Lazy Eye
Cancer if yes explain_____
Macular Degeneration Other _____

Family History
Diabetes
Hypertension
Cancer If yes, explain _____
Glaucoma if yes, whom_____
Retinal Detachment if yes whom_____
Macular Degeneration if yes whom_____

Problems with Organs or Systems (Circle ALL that apply)

Fever Weight Loss Weight Gain Urinary Pain with Blood Ear/Nose/Throat Rash(es) Where_____
Lesion(s) Where_____ Heart/Chest Pain Irregular Pulse Skeletal/Joint Pain Muscle Aches
Wheezing/Coughing Shortness of Breath Neuro-Headache Weakness Gastrointestinal/Stomach Pain
Diarrhea Blood in Stool Depression Anxiety Other_____

Other Medical Problem(s) _____

Please list ALL Surgeries Including Eye (Use the back of sheet if needed) _____

Do you have poor vision in either eye EVEN WITH GLASSES? If yes, please explain what and how it affects your daily life_____
_____