Last Eye
Exam:_____Doctor:_____
____

Do you currently wear glasses **Yes/No** How long?_____Contact Lenses **Yes/No** How long?_____

Last Medical
Exam:_____Doctor:_____Pharmacy:_____

Have you ever been exposed or infected with: Gonorrhea, Hepatitis, HIV, Syphillis

Do you have any Occupational Exposures: (such as radiation)?_____

PATIENT MEDICAL HISTORY:
Please list any allergies you may have:
_____
(Such as Drug, Seasonal, Latex, etc.....)

MEDICATIONS:
Please include all OTC and Eye drops, as well as dosage. If you have a list listed we will copy it for you.

REVIEW OF SYSTEMS:
Please circle or specify any other conditions not

Constitution: Appetite Change, Fatigue, Insomnia, Other:
Cardiovascular: Heart Disease, Hypertension, Other:
Ear, Nose, Throat: Dizziness, Ear Pain, Other:
Respiratory: Asthma, Bronchitis, Other:
Gastrointestinal: Diverticulitis, Chrons, Ulcer, Other:
Genitourinary: Bladder Infection, Kidney Infection, Other:
Musculoskeletal: Multiple Sclerosis, Scoliosis, Other:
Integumentary: Psoriasis, Lupus, Rosacea, Other:
Neurological: Epilepsy, Bells Palsy, Other:
Psychiatric: Depression, Dementia, Other:
Endocrine: Diabetes Type I, II, Thyroid, Other:
Hematologic/Lymphatic: Bleeding Disorder, Leukemia, Lymphoma, Other:
Allergic/Immunologic: Allergy Disorder, Lupus, Psoriasis, HIV-Aids, Other:
OTHER:

Past Medical History:

PLEASE CIRCLE AND SPECIFY ANY THAT APPLY TO YOU:

Glaucoma, Cataracts, ARMD, Eye Injury, Retinal Disease, Blindness, Strabismus, Amblyopia, Diabetes, Dry Eye, Other:

PLEASE CIRCLE AND SPECIFY: Family History of:

Glaucoma, Cataracts, ARMD, Eye Injury, Retinal Disease, Blindness, Strabismus, Amblyopia, Diabetes, Cancer, Heart Disease, Other:

Current Every Day Smoker, Current Some Day Smoker, Smoker, Former Smoker
Drug Use: Y/N Alcohol Use : Y/N

Height: Weight: