MEDICAL INFORMATION

Date ______________________________ Referred By ______________________________

Name ______________________________ Family Physician ______________________________

I. PAST MEDICAL HISTORY:

Medical History (Do you have any of the following):

____ Asthma
____ Arthritis
____ Cancer
  ____ *Breast Cancer*
  ____ *Colon Cancer*
  ____ *Leukemia*
  ____ *Lung Cancer*
  ____ *Lymphoma*
  ____ *Prostate Cancer*

____ Diabetes
____ Emphysema (COPD)
____ Heart Disease
  ____ *Atrial Fibrillation (Irregular Heartbeat)*
  ____ *Coronary Artery Disease*
____ Hepatitis
____ High Cholestoral *(Hypercholesterolemia)*

____ High Blood Pressure *(Hypertension)*
____ HIV
____ Stroke
____ Thyroid Disease
  ____ *Hyperthyroidism*
  ____ *Hypothyroidism*
____ Other (please list) ______________

Past Surgical History:

II. OCULAR HISTORY (List Any Eye Conditions and/or Eye Surgeries):

Eye Conditons:

Eye Surgeries:

Family History of:

Cataracts ______________________________
Crossed Eyes *(Strabismus)* ______________
Diabetes ______________________________
Eye Disorders ______________________________
Glaucoma ______________________________

Heart Disease ______________________________
High Blood Pressure *(Hypertension)* ______________
Lazy Eyes *(Amblyopia)* ______________
Retinal Detachments ______________________________
Other ______________________________

III. CURRENT MEDICATIONS:

IV. MEDICATION ALLERGIES:

V. SOCIAL HISTORY:

Drug Use ______________________________

Alcohol Use:
____ None ____ Less Than 1 Drink Per Day ____ 1-2 Drinks Per Day ____ 3 Or More Drinks Per Day

Smoking Status:
____ Current Every Day Smoker ____ Current Some Days Smoker ____ Former Smoker ____ Never Smoked

(TURN OVER)

VI. REVIEW OF SYSTEMS (Do you have any problems in the following areas? Check (✔) all that apply)

NORMAL	☐	**1) GENERAL HEALTH**	Fever	☐
NORMAL	☐	**2) EYES**	Blurred Vision	☐
NORMAL	☐	**3) EARS, NOSE, MOUTH, THROAT**	Hearing Loss	☐
NORMAL	☐	**4) CARDIOVASCULAR**	Chest Pain	☐
NORMAL	☐	**5) RESPIRATORY**	Short of Breath	☐
NORMAL	☐	**6) GASTROINTESTINAL**	Stomach Pain	☐
NORMAL	☐	**7) HEMATOLOGIC/LYMPHATIC**	Free Bleeder	☐
NORMAL	☐	**8) MUSCULOSKELETAL**	Weakness	☐
NORMAL	☐	**9) INTEGUMENTARY (SKIN/BREAST)**	Tumors	☐
NORMAL	☐	**10) NEUROLOGIC**	Numbness	☐
		11) GENITOURINARY	Currently Pregnant	☐

(TURN OVER)