MEDICAL HISTORY

Name:____________________ Occupation:____________________

Primary Doctor:____________________ Referred By:____________________

Please describe your living situation (eg. in your own home, in a nursing home etc.)____________________

Please list current medications (especially *eye* medications):

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Please list any medicines to which you have allergies: ____________________

Ocular History:			**Systemic Review of Systems**		
Do you have, or have you had:	yes	no	**Do you have:**	yes	no
Any injuries to your eyes?			High Blood Pressure		
Diseases of your eyes?			Diabetes		
Surgeries on your eyes or eyelids?			Lung Disease such as Asthma		
Wear Contact Lenses			Heart Disease		
Cataracts			Infectious Diseases such as HIV or Hepatitis		
Glaucoma			Autoimmune Diseases such as Lupus		
Macular Degeneration			Major Skin Diseases such as Acne Rosacea		
Retinal Detachment			Neurologic Diseases such as stroke		
Diabetic Retinopathy			Cancers		
Vision Loss			Severe Ear Diseases such as Menieres		
Iritis			Major Psychological problems such as psychosis		
Crossed or Wandering or Lazy Eyes			Do you take Plaquenil or choroquine?		
Eye Medications (Prescribed)			Do you take interferon?		
Any other major Eye problems			Please list any other major diseases you have:		
Please explain any yes answers.					
Do any close relatives have:			**Do you:**		
Glaucoma			Drink any alcohol?		
Macular Degeneration			Smoke?		
Blindness			Drive a vehicle?		
Any major eye disease (please list)			Use any recreational (illegal) drugs? (please list)		

____________________ ____________________ ____________________

Your Signature Today's Date Reviewed by