



PATIENTS NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_

TODAYS DATE: \_\_\_/\_\_\_/\_\_\_ **GENERAL HISTORY**

1) HAVE YOU OR ANY FAMILY MEMBER HAD ANY OF THE FOLLOWING?

	SELF	FAMILY		SELF	FAMILY
AIDS / HIV+			HIGH CHOLESTEROL		
ANEMIA			KIDNEY DISEASE		
ASTHMA / BRONCHITIS			LUNG DISEASE		
CANCER			STROKE		
DIABETES <input type="checkbox"/> Insulin <input type="checkbox"/> Non-Insulin			THYROID DISORDER		
EMPHYSEMA			ULCERS		
EPILEPSY / SEIZURE			CATARACTS		
HEPATITIS			GLAUCOMA		
HEART DISEASE / ATTACK			MACULAR DEGEN.		
HIGH BLOOD PRESSURE			RETINAL DETACH.		
<b>OTHER:</b>					

2) LIST ANY PREVIOUS SURGERIES:( INCLUDING EYES ) \_\_\_\_\_

3) DO YOU SMOKE? YES / NO IF YES, HOW MANY PACKS DAILY \_\_\_\_\_

4) DO YOU DRINK ALCOHOL? YES / NO IF YES, SOCIAL / EXCESSIVE

5) DO YOU CONSUME ANY OTHER DRUG OR ALCOHOL SUBSTANCE? YES / NO WHAT? \_\_\_\_\_

6) CURRENT MEDICATION: ( INCLUDE OVER THE COUNTER MEDS )

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

7) CIRCLE ANY ALLERGIES YOU MAY HAVE AND EXPLAIN REACTION:

NONE	CODEINE	IODINE	PENICILLIN	ADHESIVE TAPE
ASPIRIN	SULFA	NOVACAINE	ANTICOAGULANTS	SEAFOODS
ANTIBIOTICS	<b>OTHER:</b>			
<b>REACTION:</b>				

8) DATE OF LAST TETANUS SHOT? \_\_\_\_\_

9) IF FEMALE, ARE YOU OR COULD YOU BE PREGNANT? YES / NO

10) DO YOU HAVE AN ADVANCE DIRECTIVE FOR HEALTHCARE? YES / NO

11) DO YOU SUFFER FROM ANY OF THE FOLLOWING CONDITIONS:

BLURRY VISION		SINUS PROBLEMS		FLASHES OF LIGHT	
DRY EYES		HEADACHES		HALOS	
WATERY EYES		PAIN IN YOUR EYES		FLOATERS	
SEASONAL ALLERGIES		DIZZINESS		<b>OTHER:</b>	

12) DO YOU WEAR GLASSES OR CONTACT LENSES? YES / NO  
 IF YES TO CONTACTS: EXTENDED / DAILY HARD / SOFT