Eye Definition
VISION | HEALTH | STYLE

Patients
Name_____ Date of Birth_____

Please answer the following questions about your medical status and history

1. Have you ever been treated for any **Medical Conditions**? (Ex: Diabetes, High blood pressure, Arthritis)
   A. NO B. YES (please list below)

_____

_____

2. Have you ever had any **Eye Disease**? (Ex: Glaucoma, Cataract, "Lazy Eye", Retinal Detachment)
   A. NO B. YES (please list below)

_____

3. Have you ever had any surgeries? Or hospitalized?
   A. NO B. YES (please list below)

_____

4. Do you smoke? A. NO B. YES (how much) _____

5. Do you consume any alcohol? A. NO B. YES (how much)_____

6. Please list any medications:_____

7. If you have any allergies to medications, please list them:_____

8 **Family History-** Do you have any **medical** or **eye disease** that runs in your immediate family?
   A. NO B. YES (please list below)

_____

_____

Do you currently have any of the following problems? (If so, please explain in space provided)

Chronic fever, unexpected weight loss/gain, fatigue	NO	YES	
Ear/nose/throat problems (hearing loss, sinus, sore throat)	NO	YES	
Heart problems (chest pain, irregular heart beat)	NO	YES	
Respiratory problems (shortness of breath, wheezing)	NO	YES	
Gastrointestinal problems (heartburn, abdominal pain, diarrhea)	NO	YES	
Urinary problems (pain or discomfort, blood in urine)	NO	YES	
Skin problems (rashes, excessive dryness)	NO	YES	
Musculoskeletal problems (muscle aches, joint pain)	NO	YES	
Neurologic problems (numbness, weakness, headaches)	NO	YES	
Psychiatric problems (depression, anxiety)	NO	YES	