MEDICAL HISTORY

Name:_____ **DOB:** ___/___/_____ **Date:** ___/___/_____

Insurance: (Leave blank if you have given us copies of your insurance cards).

Insurance Provider: _____

Policy #_____ Group # _____

Subscriber:_____ Subscriber DOB: ___/___/_____

Do you? use Tobacco use Alcohol use Recreational Drugs (Circle all that apply)

What is your occupation:_____

What are your hobbies:_____

Eye Diseases: Which do you currently have or have had in the past?

	Yes	No		Yes	No		Yes	No
Cataracts	☐	☐	Glaucoma	☐	☐	Macular Degeneration	☐	☐
Crossed Eyes	☐	☐	Lazy Eye	☐	☐	Spots/Light Flashers	☐	☐
Detached Retina	☐	☐	Other_____					

Family Eye History: Have your grandparent, parents, brothers or sisters had any of the following?

	Yes	No		Yes	No		Yes	No
Blindness	☐	☐	Detached Retina	☐	☐	Lazy/Crossed Eye	☐	☐
Cataracts	☐	☐	Glaucoma	☐	☐	Macular Degeneration	☐	☐

Current Health Conditions: Do you have any of the following?

	Yes	No		Yes	No
Arthritis	☐	☐	Lupus	☐	☐
Asthma or Emphysema	☐	☐	Mental Health Problems	☐	☐
Blood or Bleeding Disorders	☐	☐	Other Heart Disease	☐	☐
Cancer	☐	☐	Reaction to Anesthetics	☐	☐
Diabetes (How Long?_____)	☐	☐	Seasonal Allergies	☐	☐
Ears/Mouth/Nose/Throat Disease	☐	☐	Seizure Disorder	☐	☐
Headaches other than occasional	☐	☐	Sinus Disease	☐	☐
Hepatitis A, B, or C	☐	☐	Skin Conditions	☐	☐
High Blood Pressure	☐	☐	Stomach/Intestinal Problems	☐	☐
High Cholesterol	☐	☐	Stroke/Neurological Disease	☐	☐
HIV/AIDS	☐	☐	TB or other Lung Disease	☐	☐
Irregular Heart Beat	☐	☐	Thyroid Disease	☐	☐
Kidney/Urinary/Genital Disease	☐	☐			

Other_____

Allergies List all known allergies, include medication	**Previous Surgeries** List all non-ocular surgeries	**Eye History** List eye related injuries & surgeries with dates