Medical History

List all medication allergies: ____________________

List any and all medications you take (including oral contraceptives, aspirin, over the counter and home remedies:

____

____

List all major injuries, surgeries and/or hospitalizations you have had: ____________________

____

Circle any of the conditions that you have had: CROSSED EYES LAZY EYE DROOPY EYELID GLAUCOMA PROMINENT EYES RETINAL DISEASE CATARACTS EYE INFECTIONS EYE INJURIES

Are you pregnant and/or nursing? YES NO Do you presently wear: GLASSES CONTACTS BOTH

Family Medical History

Circle any of the following medical conditions diagnosed in your maternal/paternal family. If circled, please explain and indicate familial relationship on the lines provided.

BLINDNESS CATARACT CROSSED EYES GLAUCOMA MACULAR DEGENERATION ARTHRITIS CANC ER RETINAL DETACHMENT/DISEASE DIABETES HEART DISEASE HIGH BLOOD PRESSURE KIDNEY DISEASE LUPUS THYROID DISEASE ELEVATED CHOLESTEROL

____

____

____

Social History *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

Do you use tobacco products? YES NO Have you used tobacco products in the past? YES NO

Number of years of tobacco use: __________ Do you drink alcohol? YES NO

Medical History

Circle if you have/had or are taking medication for any of the following:

FEVER CHILLS WEIGHT LOSS WEIGHT GAIN HORMONES HEARING LOSS NOSE/SINUS PROBLEM THROAT/SWALLOWING PROBLEM HIGH BLOOD PRESSURE ANGINA/CHEST PAIN HEART CONDITION SHORTNESS OF BREATH EMPHYSEMA ASTHMA HEARTBURN/REFLUX ULCER LIVER CONDITION INTESTINAL/BOWEL PROBLEM KIDNEY DISORDER DIFFICULTY URINATING LOSS OF BLADDER CONTROL RASH SKIN CONDITION SKIN CANCER JOINT PAIN/SWELLING (ARTHRITIS) ORTHOPEDIC PROBLEM BLEEDING/BRUISING PROBLEM ANEMIA CANCER HIGH CHOLESTEROL DIABETES HEADACHES THYROID CONDITION MIGRAINES DEPRESSION ANXIETY SLEEP DISTURBANCE DEMENTIA ALZHEIMERS NONE OF THE ABOVE OTHER ____________________