▲DATE (MM/DD/YY) ▲REFERRED BY ▲BIRTH DATE

▲PATIENT'S NAME ▲SEX

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc.)?
   Yes ☐ No ☐ If YES, please explain: _____
2. Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment:)?
   Yes ☐ No ☐ If YES, please explain: _____
3. Have you ever had any surgery?
   Yes ☐ No ☐ If YES, please provide date and reason _____
   _____
4. Have you ever been hospitalized?
   Yes ☐ No ☐ If YES, please provide date and reason _____
   _____
5. Do you take any medications?
   Yes ☐ No ☐ If YES, please list: _____
   Do you take any eye medications:
   Yes ☐ No ☐ If YES, Please list: _____
6. Do you have any drug or food allergies?
   Yes ☐ No ☐ If YES, please list: _____
   _____

Review of Systems	Yes	No	If YES, please explain:
Do you currently have any of the following problems?			
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	_____
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat)	☐	☐	_____
Heart problems (e.g., chest pain, irregular heart beat)	☐	☐	_____
Respiratory problems (e.g., shortness of breath, wheezing, coughing)	☐	☐	_____
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomitting)	☐	☐	_____
Urinary problems (e.g., pain or discomfort, blood in urine)	☐	☐	_____
Skin problems (e.g., rashes, excessive dryness)	☐	☐	_____
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)	☐	☐	_____
Neurologic problems (e.g., numbness, weakness, headaches, paralysis)	☐	☐	_____
Psychiatric problems (e.g., depression, anxiety)	☐	☐	_____

7. Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)
   Yes ☐ No ☐ If YES, please explain: _____
   _____
   _____
8. Do you smoke: if yes, how much? ☐ drink alcohol? if yes, how much ☐

_____

_____