Name: _____ Today's Date: _____
Date of Birth: _____ Last Eye Exam Date: _____

List any medications and/or supplements you are currently taking (Rx, painkillers, over-the-counter, contraceptives, naturopathic): _____
_____
Medication allergies? YES NO
If YES, please explain: _____
List all major illnesses (including but not limited to stroke, diabetes, high blood pressure, heart attack, etc.):
_____

Do you *currently* have any problems in the following areas? If yes, please include details

	YES	NO	Details
EYES (poor vision, pain, tearing, redness, injury, cataracts, lazy eye, drooping eyelid, infections, etc.)			
GENERAL (fever, heat stroke, weight loss, weight gain, unusual fatigue, etc.)			
EAR/NOSE/THROAT (hearing loss, ear ache, stuffy nose, cough, dry mouth, etc.)			
CARDIOVASCULAR (high blood pressure, racing pulse, history of heart attacks, etc.)			
RESPIRATORY (congestions, wheezing, shortness of breath, etc.)			
GASTROINTESTINAL (IBS, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, jaundice, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (rosaccea, rashes, eczema, acne, etc.)			
NEUOLOGICAL (numbness, headache, seizures, paralysis, etc.)			
ENDOCRINE (diabetes, thyroid, etc.)			
LYMPHATIC (bleeding, high cholesterol, anemia, blood transfusion, etc.)			
IMMUNE (allergies, sneezing, swelling, redness, itching, hives, lupus, etc.)			
PHYCHIATRIC (anxiety, depression, insomnia, etc.)			
PREGNANCY (currently pregnant or nursing, etc.)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had any these diseases? (Circle all that apply) YES NO UNKNOWN
Blindness, Cataracts, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other heritable diseases: _____

LIFESTYLE HISTORY

Does your vision limit any activities of daily living? (driving, reading, sports, work, etc.) YES NO
Do you drink alcohol? YES NO If YES, how many drinks per week? _____
Do you smoke? YES NO If YES, how much? _____ How many years? _____

Physician's Signature _____ *Date*_____