NAME:____**DATE:**_________________

CURRENT MEDICATIONS (*EYE DROPS AND PILLS*):____

____

ALLERGIES (*MEDICATION/FOOD*):____

PRIMARY CARE PHYSICIAN:____

CARDIOLOGIST:____

ARE YOU CURRENTLY EXPERIENCING ANY EYE SYMPTOMS? (*PLEASE CIRCLE ALL THAT APPLY*)

FLOATERS *FLASHES OF LIGHT* *SHADOWS* *DISTORTED VISION* *BLURRED VISION*

EYE HISTORY: (*PLEASE CIRCLE ALL THAT APPLY*)

MACULAR DEGENERATION *DIABETIC EYE DISEASE* *GLAUCOMA* *TRAUMA*

RETINAL DETACHMENT *VEIN OCCLUSION* *CATARACTS*

PREVIOUS EYE SURGERY/LASER:____

____

PREVIOUS OTHER SURGERY:____

____

MEDICAL HISTORY (CURRENT OR PREVIOUS) (*PLEASE CIRCLE ALL THAT APPLY*)

HEART DISEASE *HEART ATTACK* *PACEMAKER* *BLOOD THINNERS*

HIGH BLOOD PRESSURE *DIABETES* *ARTHRITIS* *CANCER*

PREMATURE BIRTH *THYROID*

FAMILY EYE/MEDICAL HISTORY (*PLEASE CIRCLE ALL THAT APPLY*)

MACULAR DEGENERATION *GLAUCOMA* *RETINAL DETACHMENT*

HIGH BLOOD PRESSURE *DIABETES* *HEART DISEASE* *CANCER*

SOCIAL HISTORY:

CURRENT OR PREVIOUS SMOKING HISTORY: ______***PACKS FOR*** ______ ***YEARS?*** *QUIT?* ***YES / NO***

DO YOU LIVE ALONE? ***YES / NO*** *DO YOU DRIVE?* ***YES / NO*** *DO YOU DRINK?* ***YES / NO***