

Date: _____

Name: _____

Date of Birth: _____

OCULAR HISTORY

Date of last eye exam: _____ **Place/doctor:** _____

Ever worn contact lenses? YES NO

Ever had eye surgery? YES NO

If yes, date: _____

What surgery: _____

Surgeon: _____

Do YOU have any history of the following: (please circle)

Cataract Diabetic eye disease Glaucoma Blindness

Macular degeneration Retinal detachment Strabismus Lazy eye

Other eye conditions such as eye trauma _____

LIST any eye medications, including over-the-counter drops:

Medical/Social History

Family doctor name/location: _____ **Doctor Tel#** _____

Circle any medical conditions with which you have been diagnosed:

Asthma COPD Heart disease Cancer Diabetes Migraine

Stroke/TIA Arthritis High blood pressure Low blood pressure

Sleep apnea Steroid use Kidney disease Hepatitis/Liver disease HIV

Thyroid High cholesterol Psychiatric disease

LIST any surgeries you have had on your body, excluding eyes, with dates:

LIST any medications you are taking:

LIST any over-the-counter medications/herbals/supplements:

Do you consume alcohol? YES NO

If you drink alcohol, how many drinks per week on average? _____

Have you ever used recreational drugs? YES NO

Do you smoke? YES NO

What is your occupation? _____

LIST medication or other ALLERGIES you have:

Family Medical and Ocular History

Circle any ocular conditions in your family:

Cataract Diabetic eye disease Glaucoma Macular degeneration

Retinal detachment Blindness Crossed eyes

Circle any medical conditions in your family:

Asthma COPD Heart disease Cancer Diabetes Migraine

Stroke/TIA Arthritis High blood pressure

List other significant eye or general medical problems in the family: