

Medical History -

Musculo-Skeletal:

Degenerative Arthritis	<input type="radio"/> Yes <input type="radio"/> No	
Rheumatoid Arthritis	<input type="radio"/> Yes <input type="radio"/> No	
Lupus or Other	<input type="radio"/> Yes <input type="radio"/> No	

Lungs:

Asthma/Emphysema	<input type="radio"/> Yes <input type="radio"/> No	
Tuberculosis/Sarcoidosis	<input type="radio"/> Yes <input type="radio"/> No	
Environmental Allergies	<input type="radio"/> Yes <input type="radio"/> No	

Heart:

Heart Attack(s)	<input type="radio"/> Yes <input type="radio"/> No	
Congestive heart failure	<input type="radio"/> Yes <input type="radio"/> No	
Coronary artery disease	<input type="radio"/> Yes <input type="radio"/> No	
Carotid artery disease	<input type="radio"/> Yes <input type="radio"/> No	
Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	

Blood:

High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	
Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	
Elevated Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	
Anemia/bleeding disorder	<input type="radio"/> Yes <input type="radio"/> No	
Sickle Cell or Other	<input type="radio"/> Yes <input type="radio"/> No	

Endocrine:

Diabetes	<input type="radio"/> Yes <input type="radio"/> No	
Thyroid	<input type="radio"/> Yes <input type="radio"/> No	
Other	<input type="radio"/> Yes <input type="radio"/> No	

Gastrointestinal:

Hepatitis/Jaundice	<input type="radio"/> Yes <input type="radio"/> No	
Ulcers/Bleeding	<input type="radio"/> Yes <input type="radio"/> No	

Nervous/Psychiatric:

Stroke/Paralysis/TIA	<input type="radio"/> Yes <input type="radio"/> No	
Migraine Headaches	<input type="radio"/> Yes <input type="radio"/> No	
Alzheimer's/Dementia	<input type="radio"/> Yes <input type="radio"/> No	
Depression	<input type="radio"/> Yes <input type="radio"/> No	
Seizures/MS/Other	<input type="radio"/> Yes <input type="radio"/> No	

Genitourinary:

Kidney Disease	<input type="radio"/> Yes <input type="radio"/> No	
Currently Pregnant or Nursing	<input type="checkbox"/> Pregnant <input type="checkbox"/> Nursing	

List Prior Eye Surgeries, including laser:

Which Eye and Date of surgery:

List all Medications (prescribed or over-the-counter) that you take:

Name	Taken for what Condition

Medical History -

Eye Drops:	Frequency:	Which Eye?

Family History

	Relationship to Patient
Lazy Eye/Eye Turn <input type="radio"/> Yes <input type="radio"/> No	
Blindness <input type="radio"/> Yes <input type="radio"/> No	
Glaucoma <input type="radio"/> Yes <input type="radio"/> No	
Macular Degeneration <input type="radio"/> Yes <input type="radio"/> No	
Retinal Detachment <input type="radio"/> Yes <input type="radio"/> No	
Diabetes <input type="radio"/> Yes <input type="radio"/> No	
Heart Disease <input type="radio"/> Yes <input type="radio"/> No	
Other <input type="radio"/> Yes <input type="radio"/> No	

Social History

Current Occupation: Employer

Do you drink alcohol? No Occasional 1 per day 2-3/day 4+/day

Do you smoke? No Occasional 1/2 pack/day 1 pack/day 1+ pack

Special Eyewear Needs?

- Computer (special prescriptions, special anti-glare tints or coatings) Other...
 Occupational (mechanics, plumbers, pilots)
 Safety Glasses (gardening, woodworking, welding)
 Sports/Hobbies (racquet sports, motorcycle)

Contact Lenses:

Do you currently wear, or are you interested in contact lenses? Yes No

If you previously wore contacts, what was the reason for stopping?

Current lens wear:

How many hours/day? How many days/week?

Do you sleep in your lenses? Yes No

How frequently do you replace your lenses?

Vision with my current lenses is: Good Okay Poor