PATIENT MEDICAL HISTORY

NAME: _____ DATE: _____

ALLERGIC TO: (*INCLUDE MEDICATIONS*):

_____

_____

PLEASE LIST YOUR CURRENT MEDICATIONS AND CONDITIONS:

_____

_____

_____

_____

_____

LIST YOUR CURRENT EYE DISEASES/PROBLEMS: (i.e. *Cataracts, Glaucoma*):

_____

_____

_____

LIST ANY SURGERY TO YOUR EYES:

_____

_____

DOES ANYONE IN YOUR FAMILY HAVE EYE DISEASE? (YES OR NO):

IF YES, PLEASE LIST WHO, THE RELATIONSHIP TO YOU, AND THE EYE DISEASE:

_____

_____

YOUR OCCUPATION:_____

PLEASE LIST YOUR IMMEDIATE FAMILY MEMBER (SPOUSE OR CHILDREN) IN CASE OF EMERGENCY:_____

_____

WHOM MAY WE THANK FOR REFERRING YOU TO US?

_____ Family
_____ Friend
_____ Advertisement
_____ Other