Name...Date..................................

Address..Telephone home..................................

....Telephone work..................................

....Family Physician..................................

....Who referred you to us?..........................

Social Security No..Date of Birth....................................Age

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PAST OCULAR HISTORY:

Last Eye Exam.. **Glasses:** ❑ yes ❑ no **Contact Lenses**..................................

EYE DISEASES: ❑ none

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EYE SURGERY: ❑ none

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TESTS (VFs, IVFAs etc):

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Family History of Eye Disease: ❑ none
❑ Glaucoma ❑ Cataract ❑ Macular Degeneration
❑ Other..

Family History of Medical Problems: ❑ none
❑ Diabetes ❑ Hypertension ❑ Other..........................

PAST MEDICAL HISTORY:

MEDICATIONS:

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MEDICAL ILLNESSES:

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DRUG ALLERGIES: ❑ **no** ❑ **yes** (please list)

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SURGERY:

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REVIEW OF SYSTEMS:

Medical Problems:
❑ Skin
❑ Head, Ears, Nose, Throat
❑ Lungs, Breathing, Heart, Blood Vessels
❑ Digestive System, Kidney, Genitals
❑ Bones, Joints, Muscles
❑ Neurologic or Psychiatric
❑ Cancer
❑ Exposure to Infectious Diseases

Occupation.. **Smoke:** ❑yes ❑no **Drink:** ❑yes ❑no