MEDICAL HISTORY

Name:_____Date:_____

Name of Referring Doctor:_____ Name of Family Doctor:_____

Please fill out completely

HAVE YOU HAD:
(please check)

- □ Cataract
- □ Glaucoma
- □ High eye pressures
- □ Retinal problems
- □ Eye surgery: Type(s) _____
  _____
- □ Crossed eyes
- □ Lazy eye
- □ Blind spots in vision
- □ Flashes or floaters
- □ High blood pressure
- □ Diabetes, how long? _____`_____
- □ Heart trouble
- □ Breathing problems
- □ Neurological disease
- □ Major surgeries (please list)
  _____
  _____
  _____
  _____

HAVE FAMILY MEMBERS HAD:
(If yes who?)

- □ Cataract
- □ Glaucoma
- □ Crossed eyes
- □ Lazy eye
- □ Blindness
- □ Diabetes
- □ Other eye disorders
- □ (please list)_____
  _____

DO YOU HAVE:

- □ Decreased vision
- □ Problems reading or driving
- □ Eye pain
- □ Double vision

Current medications: (please list ALL current medications: include all eye drops)

_____
_____
_____
_____
_____

Allergies to medications: _____

Do you smoke? □ Yes □ No Have you smoked? □ Yes □ No

Last eye examination: _____

Do you wear glasses? □ Yes □ No

Do you wear contact lenses? : □ Yes □ No

What brand?_____

Type of solution? _____