Patient Name: _____ Date of Birth: ___/___/_____ Today's date: ___/___/_____

Please answer ALL of the following questions regarding your general and ocular health.

Please describe the reason for your visit today: _____

_____

_____

Do you have any drug allergies? Y N If yes, please list: _____

Surgical History Year Year Year

_____ _____ _____

_____ _____ _____

Have you ever had any of the following medical problems? (Please circle yes or no)

AIDS or HIV+	Y	N	Emphysema	Y	N	Low Blood Pressure	Y	N
Anemia	Y	N	Eye Injury	Y	N	Migraine Headaches	Y	N
Arthritis	Y	N	Eye Surgery	Y	N	Pregnant or Nursing (presently)	Y	N
Asthma	Y	N	Glaucoma	Y	N	Seizure	Y	N
Bleeding tendency	Y	N	Heart attack (year) _____	Y	N	Stroke	Y	N
Blood transfusions	Y	N	Heart disease	Y	N	Thyroid disease	Y	N
Bronchitis	Y	N	Hepatitis (circle) A B C	Y	N	TIA	Y	N
Cancer of _____	Y	N	High blood pressure x ___ yrs	Y	N	Tuberculosis (year) _____	Y	N
COPD	Y	N	Hives or Eczema (circle which)	Y	N	Ulcer	Y	N
Diabetes x ____ years	Y	N	Kidney Disease	Y	N	Venereal Disease	Y	N

Are you currently experiencing any of the following symptoms? (Please circle yes or no)

Sensitivity to light	Y	N	Eye strain	Y	N	Eye pain, burning or itching	Y	N
Poor vision	Y	N	Floaters or spots in vision	Y	N	Double vision	Y	N
Eye discharge	Y	N	Excessive tearing	Y	N	Depression	Y	N
Fever / Chills	Y	N	Mouth ulcers	Y	N	Genital ulcers	Y	N
Weight Loss	Y	N	Shortness of breath	Y	N	Muscle aches	Y	N
Sinus congestion	Y	N	Diarrhea	Y	N	Rash or other skin problems	Y	N
Cough	Y	N	Abdominal pain	Y	N	Enlarged lymph nodes	Y	N
Dry mouth	Y	N	Bloody or black stool	Y	N	Immune problems	Y	N

Family History (Has one of your blood relatives had any of the following): Please note relation

Blindness _____	Y	N	Macular Degeneration _____	Y	N	Cancer _____	Y	N
Cataract _____	Y	N	Retinal Detachment _____	Y	N	Heart Disease _____	Y	N
Glaucoma _____	Y	N	Diabetes _____	Y	N	Other _____		

Do you use or have you ever used:

Tobacco or tobacco products	Y	N	___packs/day X _____ years
Alcohol	Y	N	___ drinks per week
Illegal drugs	Y	N	please list type and number of years _____

Please list ALL current medications (this includes prescription and over the counter)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____