Medical History

Date: _____ Name: _____

Primary Care Physician: _____ Physician #: _____

Are you allergic to any medication? Yes No
If yes, list them: _____

_____

List any eye drops you are using: _____
List all your medications (including vitamins): _____

_____

_____

Have you had any major surgery? _____
Have you had any eye surgery? Yes No

Type of Eye Surgery	Which eye	Year	Surgeon

Do you smoke cigarettes? No Occasionally Yes, How many per day? _____
Do you drink alcohol? No Occasionally Yes

PLEASE INDICATE WHICH *FAMILY MEMBER* APPLIES TO THE FOLLOWING:

F=Father M=Mother B=Brother S=Sister GP=Grandparents

	YES	NO
Glaucoma		
Cataract		
Macular Degeneration		
Retinal Detachment		
Strabismus (eye muscle problem)		
Diabetes		
Hypertension		
Cancer		
Other: _____		