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|----------------------|-------------------------|
| Name | _____ |
| Date of Birth | _____ Date _____ |

General Medical History

| Medical Condition | How Long? |
|-------------------|-----------|
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Surgeries

| Surgeries other than eyes | When? |
|---------------------------|-------|
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Medications, including Over the Counter Medications (including aspirin, Tylenol, Advil, etc.)

| Medication (NOT eye medication) | Dose | Number of times per day | How Long? |
|---------------------------------|------|-------------------------|-----------|
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Review of Systems

Do you currently have any of the following problems, **other than what is previously mentioned.**

| Condition | Yes | No | If Yes, Please Explain |
|---|--------------------------|--------------------------|------------------------|
| Chronic fever, unexpected weight loss/gain, fatigue | <input type="checkbox"/> | <input type="checkbox"/> | |
| Ear/Nose/Throat problems (e.g., hearing loss, sinus problems, sore throat) | <input type="checkbox"/> | <input type="checkbox"/> | |
| Heart Problems (e.g., chest pain, irregular heart beat) | <input type="checkbox"/> | <input type="checkbox"/> | |
| Respiratory Problems (e.g., shortness of breath, wheezing, coughing) | <input type="checkbox"/> | <input type="checkbox"/> | |
| Gastrointestinal Problems (e.g., heartburn, abdominal pain, diarrhea, vomiting) | <input type="checkbox"/> | <input type="checkbox"/> | |
| Urinary Problems (e.g., pain or discomfort, blood in urine) | <input type="checkbox"/> | <input type="checkbox"/> | |
| Skin Problems (e.g., rashes, excessive dryness) | <input type="checkbox"/> | <input type="checkbox"/> | |
| Musculoskeletal Problems (e.g., muscle aches, joint pain, swollen joints) | <input type="checkbox"/> | <input type="checkbox"/> | |
| Neurologic Problems (e.g., numbness, weakness, headaches, paralysis) | <input type="checkbox"/> | <input type="checkbox"/> | |
| Psychiatric Problems (e.g., depression, anxiety) | <input type="checkbox"/> | <input type="checkbox"/> | |

Family and Social History

Do any of these medical or eye diseases run in your family?

diabetes high blood pressure cancer glaucoma macular degeneration other _____

Do you smoke? Yes No If yes, how much? _____

Do you drink? Yes No If yes, how much? _____

Do you use illicit drugs? Yes No If yes, what? _____