Name_____ **Date**_____

Print name

Date of Birth _____ **Date of last eye exam** _____

List medications you currently take (prescription and over-the-counter) on the back of this page.

Do you have an **allergy** to latex? **YES** **NO**

Do you have **allergies** to any medications? **YES** **NO**

If YES, list the medication(s): _____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):_____

_____

List any **surgeries** you have had (including eye surgeries): _____

_____

Do you have any problems in the following areas? If YES, please provide additional info on the back.

		YES	NO			YES	NO
Eyes	Poor Vision			**Muscles/Bones/Joints**	Swelling		
	Eye Pain				Joint Pain		
	Dry Eyes				Arthritis		
HIV/AIDS				**Hepatitis C**			
Constitutional	Fever			**Neurologic**	Headache		
	Unusual Weight Gain/Loss				Seizures		
	Tired				Paralysis		
Respiratory	Congestion			**Genital/Bladder**	Frequent urination		
	Wheezing				Painful urination		
	Shortness of Breath				Impotence		
Gastrointestinal	Diarrhea / Constipation			**Endocrine**	Diabetes		
	Ulcers / Hernia				Thyroid		
Cardiovascular	High blood pressure			**Blood/Lymphatic**	Bleeding Disorders		
	Heart problems				High Cholesterol		
Skin	Rash			**Psychiatric**	Anxiety		
	Growths				Depression		
Females Only:	Pregnant			**Males Only:**	Prostate		
	Nursing						

CONTINUED ON BACK

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any of your immediate family members had these diseases? (father, mother, siblings, grandparents)

Blindness _____

Cataract _____

Glaucoma _____

Diabetes _____

Hypertension _____

Heart Disease _____

Stroke _____

Cancer _____

Thyroid disease _____

Arthritis _____

Other heritable disease: _____

Unknown or Adopted without knowledge of family history: _____

SOCIAL HISTORY

Does your vision limit activities of daily living (driving, reading, work, etc.)? YES ____ NO ____

Have you ever had a blood transfusion? YES ____ NO ____

Do you drink alcohol? YES ____ NO _____ If YES, how much? _____

Do you smoke? YES ____ NO _____ If YES, how much? _____ How many years? _____

VACCINATIONS

FLU	YES ____	NO _____	DATE: _____
COVID-19	YES ____	NO _____	DATE OF MOST RECENT BOOSTER: _____
PNEUMONIA	YES ____	NO _____	DATE: _____

If you have any additional information you would like to add regarding **medications you currently take, allergies to any medications, major illnesses, or any surgeries** you may have had, please specify in the box below: