



Date:

place patient's label here

|                       |        |      |                       |        |      |
|-----------------------|--------|------|-----------------------|--------|------|
| <b>FAMILY DOCTOR:</b> |        |      | <b>REFERRING DR.:</b> |        |      |
| Address:              |        |      | Address:              |        |      |
| City:                 | State: | Zip: | City:                 | State: | Zip: |
| Telephone: (    )     |        |      | Telephone: (    )     |        |      |

| HEALTH HISTORY         | Y           | N | MEDICATIONS:             |            |  |
|------------------------|-------------|---|--------------------------|------------|--|
| Diabetes               |             |   |                          |            |  |
| Hypertension           |             |   |                          |            |  |
| Heart Disease          |             |   |                          |            |  |
| Rheumatoid Arthritis   |             |   |                          |            |  |
| Lung Disease           |             |   |                          |            |  |
| Kidney Disease         |             |   |                          |            |  |
| Stomach/ Colon Disease |             |   |                          |            |  |
| Liver Disease          |             |   |                          |            |  |
| Neurological Disease   |             |   |                          |            |  |
| Seizure Disorder       |             |   |                          |            |  |
| Cancer Lymphoma        |             |   |                          |            |  |
| Autoimmune Disease     |             |   | Eye Medicines/ Vitamins: | Allergies: |  |
| Thyroid/ Gland Disease |             |   |                          |            |  |
| Skin Disease           |             |   |                          |            |  |
| HIV Positive           |             |   |                          |            |  |
| Smoking History        |             |   |                          |            |  |
| Packs per day          | _____       |   |                          |            |  |
| How long               | _____ years |   |                          |            |  |

| FAMILY HISTORY                    | Y    | N       | EYE HISTORY / DISEASE OR SURGERY OF THE EYE |                    |        |          |
|-----------------------------------|------|---------|---|--------------------|--------|----------|
|                                   |      |         | Date  | Diagnosis/ Surgery | Doctor | Location |
| Diabetes                          |      |         |   |                    |        |          |
| Glaucoma                          |      |         |   |                    |        |          |
| Crossed Eyes                      |      |         |   |                    |        |          |
| Corneal Disease                   |      |         |   |                    |        |          |
| Retina Disease                    |      |         |   |                    |        |          |
| <b>Shaded for Office Use Only</b> |      |         |   |                    |        |          |
| Updated                           | Tech | Updated | Tech  |                    |        |          |
|                                   |      |         |   |                    |        |          |

|  |  |  |                       |  |  |  |
|--|--|--|-----------------------|--|--|--|
|  |  |  | <b>OTHER SURGERY:</b> |  |  |  |
|  |  |  |                       |  |  |  |
|  |  |  |                       |  |  |  |