Name:_____ **DOB:**_____ **DATE:** _____

PERSONAL MEDICAL HISTORY (Review of systems) : PLEASE CHECK IF ANY OF THE FOLLOWING APPLY TO YOU.

IF YOU HAVE NONE OF THESE, **PLEASE CHECK NONE.**

Cardiovascular: __ **None** ___ High Blood Pressure ___ Stroke ___ Heart Disease ___ Other	**Endocrine:** ___ **None** ___ Non-Insulin Dependent Diabetes ___ Insulin Dependent Diabetes ___ Thyroid Problem ___ Pituitary Disorder	**Respiratory:** __ **None** ___ Asthma ___ COPD ___ Emphysema ___ Other:
Constitutional: __ **None** ___ Cancer ___Dizziness ___Sleep Disorder (Apnea) ___ Other:	**Dermatologic** __ **None** ___ Dry Skin ___Rosacea ___Psoriasis ___Other	**Psychiatric:** __ **None** ___ ADD (Attention Disorder) ___ Depression ___ Dementia ___ Other:
Neurological: __ **None** ___ M.S. (Multiple Sclerosis) ___ Epilepsy ___Migraine or Cluster Headache ___Parkinson's Disease ___ Other:	**Musculoskeletal:** __ **None** ____Arthritis ___ Skelatal Disorder ___ Myasthernia Gravis ___ Other:	**Immunologic:** __ **None** ___ AIDS or HIV ___ Lyme's Disease ___ Sjogren's Disease ___ Other
Hematological: __ **None** ___ Anemia ___ Leukemia ___ Blood Clotting Disorder ___ Other	**Gastrointestinal** __ **None** ___ Liver Disease ___ Colitis ___ Other:	**Ear/Nose/Throat:** __ **None** ___ Hearing Loss ___ Sinus Disease ___ Dry Mouth ___ Other
Genitourinary ___ Kidney Disease ___ Other	**Allergy** ___ Enviromental ___ Medication ___ Other	

Primary Care Physician: _____

:

Please list any medication and/or drugs that you are taking (including vitamins & supplements) or : See separate list _____

1 _____ 6 _____

2 _____ 7 _____

3 _____ 8 _____

4 _____ 9 _____

5 _____ 10 _____

Please list any eyedrops or medication you are using for your eyes: _____

_____ _____

Do you have any allergies to medication ? Yes No If yes, please list _____

Are you pregnant ? Yes No Are you nursing ? Yes No

SOCIAL HISTORY

Do you drive ? Yes No If yes, do you have visual difficulty when driving? Yes No If yes, please describe: _____

_____

Do You Smoke ?	Yes	No	Amount:	occasional	1-2 pk/day	2+ pk/day	
Do you drink alcohol ?	Yes NO	Yes	No	Amount: social	1-2/day	3+/day	alcohol dependance

Occupation :_____ Employer:_____

Hobbies: _____

FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) been diagnosed with:

___ Macula Degeneration ___ Retinal Detachment ___ Keratoconus ___ None

___ Glaucoma ___ Lazy Eye ___ Blindness ___ Unknown Family History