Patient Medical and Eye History New/Update

Name: _____

Patient Health (Circle all that apply)

Diabetes (Type 1 2) High Blood Pressure High Cholesterol Cancer Thyroid (Hyper/Hypo) Arthritis Lupus
Crohn's Multiple Sclerosis Heart Disease Other: _____

Patient Ocular History (circle all that apply)

Glaucoma Macular Degeneration Amblyopia Strabismus Cataracts Dry Eyes Allergies Injury
Other/ Explain Injury: _____
Eye surgeries: _____

Family Ocular and Health History (circle all that apply and give relationship)

Diabetes _____ Cancer _____ Glaucoma _____ Macular Degeneration _____
Other Eye Conditions _____

Current Patient Medications (if dosage is known, please list, otherwise drug name is fine)

_____

_____

Drug allergies? _____
Are you a current smoker? Y/N Are you a past smoker? Y/N
Do you wear: glasses soft contacts gas permeable contacts