Name: _____

PLEASE CHECK IF YOU HAVE ANY OF THE CONDITIONS LISTED BELOW:
IF YOU DO NOT HAVE ANY OF THESE CONDITIONS, PLEASE CHECK NONE.

Cardiovascular: ___None ___High Blood Pressure ___Elevated Cholesterol ___Stroke ___TIA ___Pacemaker ___Other:	**Head:** ___None ___Excessive Dry Mouth ___Headaches ___Migraines ___Hearing loss ___Sinusitis ___Other:	**Musculoskeletal:** ___None ___Arthritis-Rheumatoid ___Arthritis-NOT Rheumatoid ___Myasthenia Gravis ___Ankylosing Spondylitis ___Marfan Syndrome ___Other:
Constitutional: ___None ___Cancer: type_____ ___Weight Loss/Gain ___Fever ___Other:	**Hematological/Lymphatic** ___None ___Anemia ___Leukemia ___Bleeding/clotting disorder ___Other:	**Neurological:** ___None ___Cerbral palsy ___Epilepsy ___Multiple Sclerosis ___Neurofibromatosis ___Memory Loss ___Numbness or tingling ___Other:
Endocrine: ___None ___Diabetes: circle Type 1 Type 2 Date diagnosed: _____ Most recent A1C_____ ___Pituitary disease ___Thyroid disorder ___Other:	**Immunologic:** ___None ___AIDS/HIV ___Shingles ___Herpes Simplex ___Lymes Disease ___Hepatitis (Type_____) ___Other:	**Psychiatric/Behavioral:** ___None ___Depression ___Anxiety ___ADD/ADHD ___Bipolar ___Eating Disorder ___Other:
Gastrointestinal: ___None ___Acid reflux ___Colitis ___Ulcers ___Inflammatory bowel ___Other:	**Integumentary/Skin** ___None ___Rosacea ___Lupus ___Psoriasis ___Eczema ___Other:	**Respiratory:** ___None ___Asthma ___Bronchitis ___COPD ___Emphysema ___Tuberculosis ___Whooping Cough ___Other:
Genital/Urinary: ___None ___Prostate disorder ___Sexually transmitted disease ___Other:	**EYE:** ___None ___Cataracts ___Glaucoma ___Macular Degeneration ___Crossed eye/Lazy eye ___Retinal disease/detachment ___Dry Eye ___Graves Disease ___Other:	**Alcohol Use:** Y N Amount: *circle* social 1-2/week daily alcoholism **Tobacco Use:** Y N Amount: _____packs/day _____ # yrs smoking
Pregnant: Y N		

Complete Both sides

Name: _____

LIST YOUR MEDICATIONS IF YOU DID NOT BRING A PRINTED LIST:

1	8	15
2	9	16
3	10	17
4	11	18
5	12	19
6	13	20
7	14	21

ALLERGIES:

1	5	9
2	6	10
3	7	11
4	8	12

EYE Surgeries	_____**None (Self not Family)**	
___Cataract Surgery: Right Left	___LASIK/PRK/ RK (Please circle)	___Other:
___Corneal Transplant	___Retinal surgery/Detachment	
___Glaucoma Surgery/Laser	___Foreign Body Removal	
___Blepharoplasty/Lid Tuck	___Yag Laser: Right Left	

FAMILY MEDICAL INFORMATION:

Medical Disease:		**Family Member**
Diabetes	Y N	
Cancer:	Y N	
High Blood Pressure:	Y N	
Heart Disease/stroke:	Y N	
Other:		
Eye Disease:		
Cataracts	Y N	
Glaucoma	Y N	
Macular Degeneration	Y N	
Crossed eye/Lazy eye:	Y N	
Keratoconus:	Y N	
Retinal disease/detachment:	Y N	

<u>If Ages 2-20:</u>

Weight:_____lbs Height:_____

Weight: _____lbs Height: _____

Complete Both sides