Name _____ Date of Birth _____ Today's Date _____

Medical History

Do you have medication allergies? ☐ Yes ☐ No If Yes, List _____

_____

List any major surgeries or hospitalizations you have had: _____

_____

_____

Are you currently pregnant or nursing? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No If yes, how old are current lenses? _____

Type of contact lenses? ☐ Rigid ☐ Soft ☐ Extended wear

Please list any sports or hobbies in which you participate: _____

Family History

Please note any family history and indicate family member (Siblings, Parents, Grandparents, Children)

Disease/Condition	Yes	No	Relationship to You	Disease/Condition	Yes	No	Relationship to You
Blindness	☐	☐	_____	Cancer	☐	☐	_____
Cataract	☐	☐	_____	Diabetes	☐	☐	_____
Crossed Eyes	☐	☐	_____	Heart Disease	☐	☐	_____
Glaucoma	☐	☐	_____	Hypertension	☐	☐	_____
Macular Degen.	☐	☐	_____	Kidney Disease	☐	☐	_____
Retinal Detachment	☐	☐	_____	Lupus	☐	☐	_____
Arthritis	☐	☐	_____	Thyroid Disease	☐	☐	_____

Social History (The information on this form is kept strictly confidential)

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

_____

Do you use tobacco products? ☐ Yes ☐ No

Do you regularly drink alcohol? ☐ Yes ☐ No

Do you have a drug dependency? ☐ Yes ☐ No If yes, give type/amount/how long: _____

Have you been exposed or infected with: ☐ Hepatitis ☐ Gonorrhea ☐ HIV ☐ Syphilis ☐ Chlamydia

Review of Systems

Do you have problems in the following areas?

Constitutional

Fever, weight loss/Gain	☐ Yes	☐ No
Skin disease	☐ Yes	☐ No

Neurological

Headaches	☐ Yes	☐ No
Migraines	☐ Yes	☐ No
Seizures	☐ Yes	☐ No

Endocrine

Diabetes	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Other Gland Disease	☐ Yes	☐ No

Please turn this form over and complete side two

Ear Nose Mouth Throat		
Allergies/Hayfever	☐ Yes	☐ No
Dry Mouth	☐ Yes	☐ No
Respiratory		
Asthma	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Cardiovascular/Vascular		
Heart disease	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Stomach or Intestinal Disease	☐ Yes	☐ No
Kidney or Bladder Disease	☐ Yes	☐ No
Bones/Joints		
Arthritis	☐ Yes	☐ No
Joint Pain	☐ Yes	☐ No
Lymphatic/Hematologic		
Anemia	☐ Yes	☐ No
Immunological/Allergic		
Lupus	☐ Yes	☐ No
AIDS	☐ Yes	☐ No
Psychiatric Illness	☐ Yes	☐ No
Eyes		
Glaucoma	☐ Yes	☐ No
Cataract	☐ Yes	☐ No
Macular degeneration	☐ Yes	☐ No
Eye pain	☐ Yes	☐ No
Eyes burn or sting	☐ Yes	☐ No
Dry eyes	☐ Yes	☐ No
Glare problems	☐ Yes	☐ No
Light sensitive	☐ Yes	☐ No

Please **list any medications** you currently take. If you **answered "yes"** to any of the above, or **have a condition not listed**, please explain: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Doctor's Signature Date Tech Init.