Patient Name:						DC	B:			Date:	
					PATIENT MEDICAL	LINF	ORN	ЛΑ	TIO	N	
Many modical conditions a	- d n	dic	-+:01	offo			_		_	medical history as completely as po	ibla
Please check all of the cond						ctor by	Tilling	Out	youi	medical history as completely as po	ossible.
Respiratory Issues		Yes		No	Hematologic Conditions		Yes	П	No	Ear/Nose/Throat Problems	□ Yes □ No
Asthma		Yes		No	Sickle Cell		Yes		No	Sinus Problems	☐ Yes ☐ No
Emphysema		Yes		No	High Cholesterol	П	Yes		No	Dental Problems	☐ Yes ☐ No
Skin Conditions	П	Yes		No	Allergy/Immunology		Yes		No	Neurological Disorder	☐ Yes ☐ No
Eczema	П	Yes		No	Hay Fever	П	Yes		No	Migraine Headaches	☐ Yes ☐ No
Rosacea		Yes		No	Sjogren's Syndrome		Yes		No	Multiple Headaches	☐ Yes ☐ No
Endocrine Disorder		Yes		No	Rheumatoid Arthritis		Yes		No	Multiple Sclerosis	☐ Yes ☐ No
Diabetes		Yes		No	Lupus		Yes		No	Myasthenia Gravis	☐ Yes ☐ No
Thyroid Disorder		Yes		No	Fever/Fatigue/Weight Loss		Yes		No	Head Injury	☐ Yes ☐ No
Gastrointestinal Issues		Yes		No	Musculoskeletal Conditions		Yes		No	Stroke	☐ Yes ☐ No
Heartburn		Yes		No	Osteoporosis		Yes		No	Kidney/Bladder Problems	☐ Yes ☐ No
Cardiovascular Conditions				No	Psychiatric Disorder		Yes		No	Sexually Transmitted Diseases	☐ Yes ☐ No
High Blood Pressure				No	Anxiety		Yes		No	Cancer	☐ Yes ☐ No
Heart Failure		Yes		No	Depression		Yes		No	Surgical Operations	☐ Yes ☐ No
					·					•	
Have you previously had any	y ey	e inju	ries,	eye su	irgeries or eye diseases?		Yes		No	If yes, please describe:	
frequent styes/chalazions, c	or ex	cessi	ve te	earing/		-	Yes		No	If yes, please describe:	
Do you have light sensitivity Do you have issues with glan				_			Yes Yes		No No	☐ Sometimes ☐ Sometimes	
Are you currently being trea	ited	for a	ny o	ther m	edical conditions?		Yes		No	If yes, please describe:	
Please list any medications	you	are c	urrei	ntly tak	king (Including hormones, vitamins, bir	th contro	ol, aspii	rin, o	ther an	nti-inflammatory, eye drops, etc.) :	□ None
Date of last general health e	exan	า:			Date of last eye exam:				Prev	vious eye care provider:	
Do you drink alcohol? 🗆 Y	co? 'es	□ Y □ No	es [	□ No Soc	□ NoLess than 1 Pack a Day ial1-2 Drinks DailyAbo No If yes, please list:  CONTACT LENS I	ve Ave	rage l	Jse		Dependence	
Do you currently wear conti	ort	anses	ے د۔	Ves							
										v away your lenses?	
										?	
Do your eyes rectury willing	Weu	шь.			•	e io oi.	dii y	)Ui .	disco		
· · · · · · · · · · · · · · · · · · ·	-1				Y HISTORY					For Office Use	<u>Only</u>
Has anyone in your family h		-			_					L FDT	РНОТО
Blindness*		Yes			Relationship:						
Cancer*		Yes			Relationship:						
Cataract Color Blindness*				No No	Relationship:				_		
Diabetes*	П	Yes Yes		No No	Relationship:				_		
Glaucoma*	_	Yes		No No	Relationship:						
Heart Disease		Yes			Relationship:						
High Blood Pressure*				No No	Relationship:						
Lazy Eye*		Yes Yes		No No	Relationship: Relationship:						
Macular Degeneration*		Yes		No	Relationship:					A   O	
Respiratory Disease		Yes		No	Relationship:						

☐ Yes ☐ No \*Additional testing may be covered through your medical insurance.

Relationship:

Retinal Detachment\*