MEDICAL HISTORY

DO YOU HAVE ANY OF THE FOLLOWING PROBLEMS?

	YES	NO
Diabetes	______	______
High Blood Pressure	______	______
Emphysema	______	______
Bleeding Tendencies	______	______
Shortness of Breath	______	______
Nervous Disorder	______	______
Do you Smoke?	______	
Usage: pk/day	____________	

	YES	NO
Heart Disease	______	______
Cancer	______	______
Epilepsy	______	______
Asthma	______	______
Hepatitis	______	______
HIV	______	______
Do you drink Alcohol?	______	______
Usage:	____________	

Other: ____

HAVE YOU HAD ANY PREVIOUS SURGERY? YES ______ NO ______

If yes, what type? ____

HAVE YOU HAD ANY PREVIOUS PROBLEMS WITH YOUR EYES? YES ______ NO ______

If yes, what type? ____

HAVE YOU HAD ANY EYE SURGERY? YES ______ NO ______

If yes, what type? ____

DOES YOUR FAMILY HAVE A HISTORY OF EYE DISEASE? YES ______ NO ______

If yes, what type? ____

ARE YOU PRESENTLY ON ANY MEDICATIONS? YES ______ NO ______
If yes, list medication and dosage

Medication	Dosage

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO ______________________

PATIENT'S SIGNATURE: ____