Medical History

Have you ever been diagnosed with any of the following? Please check all that apply:

- ☐ Developmental Disabilities
- ☐ Chronic Fatigue Syndrome
- ☐ Cancer

- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis

- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Stroke / CVA
- ☐ Migraine
- ☐ Autism Spectrum Disorder

- ☐ Depression
- ☐ Attention Deficit Disorder (ADD/ADHD)
- ☐ Anxiety
- ☐ Bipolar Disorder

- ☐ Environmental Allergies
- ☐ Drug Allergies

- ☐ Hypertension
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart Failure

- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstruction
- ☐ Sleep Apnea

- ☐ Chron's Disease
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux
- ☐ Celiac Disease

- ☐ Kidney Disease
- ☐ Prostate Disease / Cancer
- ☐ STD - Herpetic / Chlamydia
- ☐ Benign Prostate Hypertrophy
- ☐ Pregnant or Nursing

- ☐ Other - Please Specify:
  _____
  _____

- ☐ Arthritis
- ☐ Osteoarthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Gout

- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Herpes Simplex/Cold Sores
- ☐ Herpes Zoster / Shingles

- ☐ Diabetes - Type I or II
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction

- ☐ Anemia
- ☐ Large-Volume Blood Loss
- ☐ Ulcer
- ☐ Hypercholesterolemia

- ☐ Sjorgen's Syndrome
- ☐ Lupus
- ☐ Rheumatoid Arthritis

Please list any medications you take on a daily, weekly, or monthly basis (including injections, inhalers, dialysis, ect.) :

_____

_____

_____

_____

_____

_____

_____

Medical History

Please list any allergies you have to medications or latex:

_____

_____

_____

Do you currently have or have a history of any of the following eye conditions?
Please check all that apply:

- ☐ Glaucoma/Glaucoma Suspect
- ☐ Cataract
- ☐ Age-Related Macular Degeneration
- ☐ Retinal Degeneration
- ☐ Retinal Hole/Detachment
- ☐ Patching
- ☐ Inflammatory Disorder
- ☐ Strabismus
- ☐ Amblyopia
- ☐ Nystagmus
- ☐ Keratoconus
- ☐ Injury
- ☐ Dry Eye
- ☐ Surgery

Do you have a FAMILY HISTORY of any of the following?
Please check all that apply:

- ☐ Glaucoma/Glaucoma Suspect
- ☐ Cataract
- ☐ Age-Related Macular Degeneration
- ☐ Retinal Degeneration
- ☐ Retinal Hole/Detachment
- ☐ Patching
- ☐ Inflammatory Disorder
- ☐ Strabismus
- ☐ Amblyopia
- ☐ Nystagmus
- ☐ Keratoconus
- ☐ Dry Eye
- ☐ Other

Do you drink alcoholic beverages? **YES** **NO**

If yes, about how often/how much? _____

Do you smoke tobacco products? **YES** **NO**

If yes, about how often/how much? _____

✗ _____

Date:_____

(Signature of Patient OR Guarantor if Patient is Under 16 Years Old)

Please bring completed form to your appointment.