Ocular History (Check all that apply)

Glaucoma	
Cataracts	
Macular Degeneration	
Retinal Detachment/Hole/Tear	
Infection of Eye or Lid	
Amblyopia	
Excessive Tearing/Watering	
Discharge	
Foreign Body Sensation	
Sandy/Gritty Feeling	
Strabismus (Lazy Eye)	

Eye Pain or Soreness	
Flashes or Floaters	
Diabetic Retinopathy	
Loss of Vision	
Double Vision	
Poor Peripheral Vision	
Headache	
Eye Turn	
Eye Injury/Trauma	
Eye Surgery	
Plaquenil or High Risk Meds	

Medical History (Check all that apply)

Heart Disease	
Stroke	
Hypertension	
Elevated Cholesterol	
Diabetes Mellitus Type I	
Diabetes Mellitus Type II	
Thyroid Disorder	
Asthma	
Cancer	
HIV Positive	

Chronic Obstruction Pulmonary Disease (COPD)	
Bell's Palsy	
Multiple Sclerosis	
Epilepsy	
Sjogren's Syndrome	
Lupus	
Rheumatoid Arthritis	
Myasthenia Gravis	
Pregnant/Breastfeeding	
Other:	

Family History (Indicate which family member)

Heart Disease	
Stroke	
Hypertension	
Elevated Cholesterol	
Diabetes Mellitus Type I	
Diabetes Mellitus Type II	
Thyroid Disorder	
Cancer	

Glaucoma	
Macular Degeneration	
Cataracts	
Blindness	
Strabismus	
Retinal Detachment	
Retinitis Pigmentosa	
Other: please specify	

Please list all medications and supplements, including dosage

_____
_____
_____

Please list all allergies (Medications, Seasonal, Other Substances, etc.)

_____

Primary Care Physician (PCP)

PCP Name _____ Clinic Name _____

Diabetic Patients:

What was your most recent A1C date and results? _____

Use of Alcohol? (Circle One) No Rarely Moderately Daily

Use of Tobacco? (Circle One) No Yes **If yes, current packs per day?** _____