



Medical History Please check YES or NO. If YES, when or how long?

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>	Asthma _____
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Difficulty _____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke _____	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis _____
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Problem or Heart Attack _____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Liver Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Rashes/Hives _____
<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies/Hayfever _____	<input type="checkbox"/>	<input type="checkbox"/>	AIDS _____
<input type="checkbox"/>	<input type="checkbox"/>	Herpes Simplex or Shingles _____	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disorder _____
<input type="checkbox"/>	<input type="checkbox"/>	Inflammatory Bowel Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Connective Tissue Disease _____

Other Medical Problems (Please describe): _____

Females: Are you pregnant, nursing, or planning to become pregnant soon? YES NO

Prior Surgeries

Date of Surgery	Type of Surgery
_____	_____
_____	_____
_____	_____

CURRENT MEDICATIONS	Amount (mg)	Times Per Day	CURRENT MEDICATIONS	Amount (mg)	Times Per Day

Social History

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Smoke: How much? _____
<input type="checkbox"/>	<input type="checkbox"/>	Drink: How much? _____

Allergies to Medications

Family History

Do any of your blood relatives have the following conditions?

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Amblyopia/Lazy Eye/Crossed Eyes
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment

Patient Printed Name _____

Patient Signature _____

Date: _____