

Date:

Medical Information:

Have you had, or do you currently have, any of the following? Check all that apply.

- 1) Constitutional Symptoms: fever weight loss chills fatigue weakness
 - 2) Eyes: blurred vision burning tearing gritty / sandy feeling itching dryness eye pain
 poor color vision glaucoma loss of vision flashes of light floating spots (floaters)
 double vision headaches
 - 3) Ears / Nose / Mouth: poor hearing hearing aid sinus problems Sjogren's syndrome dry mouth
 - 4) Cardiovascular: high blood pressure poor circulation high cholesterol heart flutter pacemaker
 heart symptoms edema (swelling) previous heart surgery
 - 5) Respiratory: shortness of breath asthma emphysema Tuberculosis lung cancer
 - 6) Gastrointestinal: upset stomach ulcer(s) esophageal reflux gastritis ulcerative colitis diarrhea
 - 7) Genitourinary: burning with urination frequency of urination enlarged prostate prostate cancer
 - 8) Musculoskeletal: arthritis muscle pain or aches muscle weakness back pain
 - 9) Skin: rash eczema psoriasis hair loss dry / itchy skin or scalp rosacea
 - 10) Neurological: seizure disorder dizziness fainting spells weakness on one side stroke
 multiple sclerosis transient ischemic attack peripheral neuropathy
 - 11) Psychiatric: depression anxiety hospitalization for mental health bipolar disorder schizophrenia
 - 12) Endocrine: juvenile Diabetes Diabetes Type I Diabetes Type II excessive weight gain/loss
 excessive thirst/urination get up frequently in night to urinate
 - 13) Hematology / Lymphatic: blood disorder excessive bleeding blood clotting problem bruise easily
 - 14) Allergy / Immunology: seasonal allergies other allergies autoimmune disease sarcoidosis
 immunologic problems Lupus scleroderma rheumatoid arthritis shingles
- Other Medical Conditions not listed: _____

Current Medications: None Allergies to Medications: _____ None known

1)	3)	5)	7)
2)	4)	6)	8)

Name of your Medical Doctor: _____

Past Surgical History: _____

Family History: glaucoma macular degeneration retinal detachment cataracts
 diabetes stroke eye turn other

If yes, please tell us who is affected: _____

Tobacco Use: yes, currently. If yes, how much/ how often? _____ previously. none

Alcohol Intake: yes, currently. If yes, how much, how often? _____ previously. none

Vision or Eye-related Concerns:

****Please Initial Here:** _____