

Name: _____ Medical History – check the box to the **LEFT** of problems that apply to you

Past Ocular History		Ocular Procedures		Diseases that may affect eyes		Eye Symptoms	
<input type="checkbox"/>	Cataracts	<input type="checkbox"/> Cataract surgery		<input type="checkbox"/> Anemia		<input type="checkbox"/> Change in vision (recent)	
<input type="checkbox"/>	Diabetic retinopathy	<input type="checkbox"/> Laser after cataract surgery		<input type="checkbox"/> Ankylosing spondylitis		<input type="checkbox"/> Double vision	
<input type="checkbox"/>	Glaucoma	<input type="checkbox"/> Laser for glaucoma		<input type="checkbox"/> Crohn's disease		<input type="checkbox"/> Discharge from eyes	
<input type="checkbox"/>	Lazy or crossed eye	<input type="checkbox"/> LASIK/PRK		<input type="checkbox"/> Diabetes, circle type: 1 2		<input type="checkbox"/> Distorted vision	
<input type="checkbox"/>	Macular degeneration	<input type="checkbox"/> Macular degeneration injections		<input type="checkbox"/> On insulin? Circle: yes / no		<input type="checkbox"/> Dry eyes	
<input type="checkbox"/>	Retinal detachment	<input type="checkbox"/> Macular hole surgery		<input type="checkbox"/> Graves' disease		<input type="checkbox"/> Floaters	
<input type="checkbox"/>	Other:	<input type="checkbox"/> Retinal detachment surgery		<input type="checkbox"/> High blood pressure		<input type="checkbox"/> Flashing lights	
Systemic Illnesses		<input type="checkbox"/> RK surgery		<input type="checkbox"/> Hyperthyroidism		<input type="checkbox"/> Glare or light sensitivity	
<input type="checkbox"/>	Alzheimers disease	<input type="checkbox"/> Strabismus (muscle) surgery		<input type="checkbox"/> Hypoglycemia		<input type="checkbox"/> Itching	
<input type="checkbox"/>	Arthritis	<input type="checkbox"/> Glaucoma surgery		<input type="checkbox"/> Hypothyroidism		<input type="checkbox"/> Pain in or near eyes	
<input type="checkbox"/>	Asthma	<input type="checkbox"/> Other:		<input type="checkbox"/> Lupus/auto-immune disease		<input type="checkbox"/> Red eyes	
<input type="checkbox"/>	Bleeding disorder	<input type="checkbox"/> Head or Eye Injury – write details:		<input type="checkbox"/> Multiple sclerosis		<input type="checkbox"/> Shadow in vision	
<input type="checkbox"/>	Cancer – Write type:			<input type="checkbox"/> Plaquenil use		<input type="checkbox"/> Tearing	
		Social History		<input type="checkbox"/> Psoriasis		<input type="checkbox"/> Other:	
<input type="checkbox"/>	Congestive heart failure	<input type="checkbox"/> Do you smoke?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Rheumatoid arthritis		Family History	
<input type="checkbox"/>	COPD (emphysema)	<input type="checkbox"/> Do you drink alcohol?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Sarcoidosis		<input type="checkbox"/> Amblyopia	
<input type="checkbox"/>	Depression	<input type="checkbox"/> Occupation:		<input type="checkbox"/> Sickle cell disease		<input type="checkbox"/> Blindness	
<input type="checkbox"/>	GERD	<input type="checkbox"/> Medication allergies (please list)		<input type="checkbox"/> Ulcerative colitis		<input type="checkbox"/> Cataract	
<input type="checkbox"/>	Hearing loss					<input type="checkbox"/> Glaucoma	
<input type="checkbox"/>	Heart attack history			Infections		<input type="checkbox"/> Macular degeneration	
<input type="checkbox"/>	Heart disease	<input type="checkbox"/> General Surgeries		<input type="checkbox"/> AIDS/HIV positive		<input type="checkbox"/> Retinal detachment	
<input type="checkbox"/>	Heart murmur	<input type="checkbox"/> Arthroscopic knee surgery		<input type="checkbox"/> Chicken pox		<input type="checkbox"/> Anesthesia complications	
<input type="checkbox"/>	High cholesterol	<input type="checkbox"/> Back surgery		<input type="checkbox"/> Hepatitis		<input type="checkbox"/> Diabetes	
<input type="checkbox"/>	Kidney disease	<input type="checkbox"/> Coronary angioplasty		<input type="checkbox"/> Herpes simplex virus		<input type="checkbox"/> Heart disease	
<input type="checkbox"/>	Lung disease	<input type="checkbox"/> Coronary artery bypass		<input type="checkbox"/> Histoplasmosis		<input type="checkbox"/> High blood pressure	
<input type="checkbox"/>	Migraine	<input type="checkbox"/> Coronary artery stents		<input type="checkbox"/> Rheumatic/scarlet fever		<input type="checkbox"/> Migraine headaches	
<input type="checkbox"/>	Psychiatric disorder	<input type="checkbox"/> Hip replacement		<input type="checkbox"/> Shingles (Herpes zoster)		<input type="checkbox"/> Sickle cell disease	
<input type="checkbox"/>	Stomach/duodenal ulcer	<input type="checkbox"/> Knee replacement		<input type="checkbox"/> Syphilis		<input type="checkbox"/> Stroke or TIA	
<input type="checkbox"/>	Stroke history	<input type="checkbox"/> Mastectomy		<input type="checkbox"/> Tuberculosis		<input type="checkbox"/> Other:	
<input type="checkbox"/>	List any other problems:	<input type="checkbox"/> List any other surgeries:		<input type="checkbox"/> Medications: Please provide list			
<input type="checkbox"/>				<input type="checkbox"/> or write on reverse side			