Social History:

Do you have visual difficulty when driving? Yes ☐ No ☐ If yes, please explain:_____

_____

Do you use tobacco products? Yes ☐ No ☐ If yes, type/amount/how long:_____
Do you drink alcohol? Yes ☐ No ☐ If yes, type/amount/how long:_____
Do you use addictive agents? Yes ☐ No ☐ If yes, type/amount/how long:_____

Have you been infected with: Gonorrhea ☐ Syphilis ☐ HIV ☐ Hepatitis ☐ None ☐

Past History:

Do you take medications (including prescriptions, oral contraceptives, aspirin, over the counter medications and home remedies): Yes ☐ No ☐
If yes, please list:

_____

_____

Have you had past injuries? Yes ☐ No ☐ If yes, please list: _____

Have you had past surgery? Yes ☐ No ☐ If yes, please explain: _____

Are you currently pregnant? Yes ☐ No ☐ If yes, expected due date? _____

Are you allergic to any medications: Yes ☐ No ☐
If yes, please list:

_____

Family History:

Please check box if anyone in the family (parents, grandparents, brothers/sisters, or children) has had any of the following conditions:

	Yes	No		Yes	No
Blindness	☐	☐	Diabetes	☐	☐
Cataract	☐	☐	Heart Disease	☐	☐
Crossed Eyes	☐	☐	High Blood Pressure	☐	☐
Glaucoma	☐	☐	Kidney Disease	☐	☐
Macular Degeneration	☐	☐	Lupus	☐	☐
Retinal Detachment/Disease	☐	☐	Thyroid Disease	☐	☐
Arthritis	☐	☐	Other	☐	☐
Cancer	☐	☐			

Patient Signature	Date	Initial if No Change