**Family History** (CIRCLE ANY THAT APPLY AND GIVE RELATIONSHIP TO PATIENT)

Lazy Eye_____
Blindness_____
Cataracts_____
Glaucoma_____
Keratoconus_____
Retinal Detachment_____
Macular Degeneration_____
Other_____

## PATIENT MEDICATIONS AND MEDICAL HISTORY

**Medications** (Including Eye Drops) **Reason Taken**

_____ _____
_____ _____
_____ _____

## PATIENT MEDICAL HISTORY
( PLEASE CIRCLE ALL THAT APPLY)

**ALLERGY**

**MEDICATION ALLERGIES:**_____

**ANY OTHER ALLERGIES:**_____

**CARDIOVASCULAR**
HEART DISEASE
ELEVATED CHOLESTEROL
HIGH BLOOD PRESSURE / HEART ATTACK

**CONSTITUTIONAL**
ANEMIA
FEVER
WEIGHT LOSS / GAIN

**ENDOCRINE**
DIABETES
GOUT
THYROID DISEASE
RENAL DISEASE

**GASTROINTESTINAL**
ACID-REFLUX SYNDROME
CANCER: COLON / LIVER
GALLBLADER DISEASE
ULCER

**GENITOURINARY**
PREGNANCY
MENOPAUSE
CANCER: UTERINE / OVARIAN / BREAST

**OTHER:**_____

_____

_____

**IMMUNOLOGIC**
AIDS
SARCOIDOSIS
SJOGREN'S SYNDROME

**INTEGUMENTARY**
ACE ROSACEA
DERMATITUS
LUPUS

**MUSCULOSKELETAL**
ARTHRITIS
MUSCULAR DYSTROPHY
MYASTHENIA GRAVIS
OSTEOPOROSIS

**NEUROLOGICAL**
BRAIN DAMAGE / TUMOR
SEIZURE DISORDER
MULTIPLE SCLEROSIS
PARKINSON'S DISEASE

**PSYCHIATRIC**
DEMENTIA
DEPRESSION
MEMORY LOSS

**RESPITORY**
ASTHMA
CANCER: LUNG
COPD