

Neurological <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Tumor <input type="checkbox"/> Other <input type="checkbox"/> NONE	Psychiatric <input type="checkbox"/> ADHD <input type="checkbox"/> Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other <input type="checkbox"/> OCD <input type="checkbox"/> NONE	Endocrine <input type="checkbox"/> Non-Insulin Dependent Diabetes <input type="checkbox"/> Insulin Dependent Diabetes <input type="checkbox"/> Thyroid Problem <input type="checkbox"/> Hormone Dysfunction <input type="checkbox"/> Other <input type="checkbox"/> NONE	Hematological <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Other <input type="checkbox"/> NONE
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Immunologic <input type="checkbox"/> AIDS or HIV <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Neurofibromatosis <input type="checkbox"/> Other <input type="checkbox"/> NONE	<input type="checkbox"/> Pregnant <input type="checkbox"/> Nursing <input type="checkbox"/> NA <input type="checkbox"/> NO Drug Allergies	List ALLERGIES and Physical Reactions <input type="checkbox"/> Drug <input type="checkbox"/> Environmental
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Medications and/or drugs (including herbal) that you are taking.

Attach a detailed list if more than 6 medications. Returning patients may also receive a printout of previous medications to compare on your exam date.

1 _____ for _____	4 _____ for _____
2 _____ for _____	5 _____ for _____
3 _____ for _____	6 _____ for _____

YOUR FAMILY HISTORY - Has anyone in your family living or deceased been diagnosed with:
Codes: GP-grandparent, P-parent, S-sibling, CH-child, A-aunt, U-uncle
Returning patients may update changes since last eye exam.

Yes/No	Blindness_____	Yes/No	Cancer_____
Yes/No	Cataract_____	Yes/No	Diabetes_____
Yes/No	Glaucoma_____	Yes/No	Heart Disease_____
Yes/No	Macular Degeneration_____	Yes/No	High Blood Pressure_____
Yes/No	Retinal Detachment_____	Yes/No	Kidney Disease_____
Yes/No	Crossed Eyes_____	Yes/No	Lupus_____
Yes/No	Arthritis_____	Yes/No	Thyroid Disease_____

SOCIAL HISTORY

Yes/No	Do you wear eyeglasses?	___ All the time	___ For Office Work
		___ Occasionally	___ Reading Only
		___ Driving Only	___ Sunglass Protection
Yes/No	Do you wear contact lenses?	Soft	Gas Permeable
		Brand_____	
Yes/No	Alcohol Use	Occasional	1/day 2-3/day 4+/day
Yes/No	Tobacco Use	Occasional	1/2 pack/day 1pack/day
			1+pack/day Chew