## Patient’s Past Medical History

**(mark yes or no to each question)**

| Condition | Response | Condition | Response |
|---|---|---|---|
| HIV/ AIDS | ❑ Yes ❑ No | | |
| Arthritis | ❑ Yes ❑ No | Hypercholesterolemia (high cholesterol) | ❑ Yes ❑ No |
| Asthma | ❑ Yes ❑ No | Hypertensive disorder (Hypertension) | ❑ Yes ❑ No |
| Cancer | ❑ Yes ❑ No | Seasonal allergy | ❑ Yes ❑ No |
| (COPD) | ❑ Yes ❑ No | Thyroid dysfunction | ❑ Yes ❑ No |
| Diabetes mellitus | ❑ Yes ❑ No | Mental disorder | ❑ Yes ❑ No |
| Emphysema | ❑ Yes ❑ No | Rheumatoid arthritis | ❑ Yes ❑ No |
| Heart disease | ❑ Yes ❑ No | | |

---

## Family Health History

**(mark yes or no to each entry. If yes, list which family member including mother, father, brother, sister, maternal/paternal grandmother or maternal/paternal grandfather)**

| Condition | Response | Condition | Response |
|---|---|---|---|
| Amblyopia (Lazy eye) | ❑ Yes ❑ No __________ | Strabismus (cross eyes) | ❑ Yes ❑ No _____________ |
| Blindness and/or vision impairment | ❑ Yes ❑ No __________ | Arthritis | ❑ Yes ❑ No _____________ |
| Cataract | ❑ Yes ❑ No ___________ | Cancer | ❑ Yes ❑ No _____________ |
| Macular Degeneration | ❑ Yes ❑ No __________ | Diabetes mellitus | ❑ Yes ❑ No _____________ |
| Glaucoma | ❑ Yes ❑ No ___________ | Cardiovascular disease | ❑ Yes ❑ No _____________ |
| Hypertension (high blood pressure) | ❑ Yes ❑ No ___________ | Stroke | ❑ Yes ❑ No _____________ |
| Retinal disorder | ❑ Yes ❑ No ___________ | | |

---

### Social History (check one for each question)

Are you a drug user? ❑ Yes ❑ No

Are you a: ❑ Non-drinker ❑ Social drinker

### Tobacco Use (mark which one applies)

❑ Heavy tobacco smoker ❑ Light tobacco smoker

❑ Never a smoker ❑ Former smoker

---

### Medications

List all CURRENT prescriptions, over-the-counter prescriptions, eye drops and dosages for each.

______________________________________________

______________________________________________

______________________________________________

______________________________________________

❑ No Medications

### Medication Allergies

List any allergies you may have and reaction.

______________________________________________

______________________________________________

______________________________________________

______________________________________________

❑ No Medication Allergies