

PAST HISTORY

List any medications you take: _____

IF YOU TAKE MULTIPLE MEDICATIONS, PLEASE BRING A LIST

List all major illnesses and injuries you have had in the past: _____

List any surgeries you have had in the past: _____

Do you have allergies to any medications? YES NO

If YES, list medications: _____

FAMILY HISTORY

Diseases

Has anyone in your family had any of the following? If **"YES,"** mark the box and give an explanation:

Blindness	_____
Cataract	_____
Glaucoma	_____
Macular degeneration	_____
Retinal detachment	_____
Arthritis	_____
Cancer	_____
Diabetes	_____
Heart Attacks	_____
High blood pressure	_____
Other	_____
NONE OF THE ABOVE APPLY	_____

SOCIAL HISTORY

Current occupation: _____

Do you drive? YES NO

Do you have visual difficulty when driving? YES NO

Do you have a problem with night vision? YES NO

Have you ever tried to wear contacts? YES NO

Do you currently wear glasses? YES NO

If YES, how long have you had the current pair? _____

Do you drink alcohol? YES NO

If YES, how many glasses a day? _____

Do you smoke? YES NO

If YES, how many packs a day and for how long? _____

Reviewed by _____ Date _____