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**MEDICAL HISTORY**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Referring Physician: \_\_\_\_\_

**CHECK MAJOR ILLNESSES AND SURGERIES**

<b>EYE HISTORY</b>	<b>YES</b>	<b>NO</b>	<b>MEDICAL HISTORY</b>	<b>YES</b>	<b>NO</b>
Cataract			Anesthesia Complications		
Double Vision			Arthritis		
Glaucoma			Asthma /Breathing Problems		
Lazy Eye			Atrial Fibrillation		
Macular Degeneration			Bleeding Disorder		
Retinal Detachment			Cancer		
Other Eye Conditions			Diabetes		
			Emphysema / Chronic Bronchitis		
			Heart Disease		
<b>EYE SURGERY</b>			High Blood Pressure		
Cataract RT / LT			Hepatitis		
Retinal Detach. RT / LT			Kidney Disease / Dialysis		
Laser Surgery RT / LT			Pacemakers		
Previous Eye Surgeon			Seizures		
Other			Stroke		
			Other		

**FAMILY HISTORY, PLEASE CHECK**

<b>DISEASE</b>	<b>YES</b>	<b>NO</b>	<b>RELATIONSHIP</b>
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Social History			
Other			

<b>WITH GLASSES DO YOU HAVE DIFFICULTY WITH ANY OF THE FOLLOWING?</b>	<b>YES</b>	<b>NO</b>
Reading Small Print (medicine bottles, telephone books)		
Reading Newspapers or Books		
Reading Large Print Books		
Recognizing People when they are Close to You		
Seeing Steps, Stairs or Curbs		
Doing Fine Hand Work (sewing, knitting or carpentry)		
Playing Games (bingo, dominos or card games)		
Playing Sports Activities (bowling, handball, tennis or golf)		
Watching Television		
Daytime Driving		
Nighttime Driving		

