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MEDICAL HISTORY

Patient name _____ Age _____ Height _____ Weight _____

Referring Physician: _____ Date: ____/____/_____

CHECK MAJOR ILLNESSES AND SURGERIES

EYE HISTORY	YES	NO	MEDICAL HISTORY	YES	NO
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		
			High Blood Pressure		
EYE SURGERY			Hepatitis		
Cataract RT / LT			Kidney Disease / Dialysis		
Retinal Detach. RT / LT			Pacemakers		
Laser Surgery RT / LT			Seizures		
Previous Eye Surgeon			Stroke		
Other			Other		

FAMILY HISTORY, PLEASE CHECK

DISEASE	YES	NO	RELATIONSHIP
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Social History			
Other			

WITH GLASSES DO YOU HAVE DIFFICULTY WITH ANY OF THE FOLLOWING?

	YES	NO
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		

