Name:	Date:
Date of Birth:	Date of last eye exam:
List major illnesses or injuries:	
List any surgeries you have had:	

Do you or any immediate family members have the following conditions? Circle those affected.

		Details, if needed
Blindness	Self, mother, father , grandparent , sibling	
Cataracts	Self, mother, father , grandparent , sibling	
Glaucoma	Self, mother, father , grandparent , sibling	
Macular Degeneration	Self, mother, father , grandparent , sibling	
Cancer	Self, mother, father , grandparent , sibling	
Diabetes	Self, mother, father , grandparent , sibling	
Hypertension	Self, mother, father , grandparent , sibling	
Heart Disease	Self, mother, father , grandparent , sibling	
Stroke	Self, mother, father , grandparent , sibling	
Thyroid Disease	Self, mother, father , grandparent , sibling	
Arthritis	Self, mother, father , grandparent , sibling	
Other	Self, mother, father , grandparent , sibling	

Social History

	Yes/No	Amount Per Day	Allergies: Yes No
Caffeine			Please list any allergies:
Alcohol			
Drug use: Yes No Former			
Smoke: Yes No Former			

In the past year have you fallen?	Yes No	If yes how many times? _____
Did the fall result in injury?	Yes No	Type of injury

Please list any medications that you currently take. Use the back of the page if necessary.

Name	Dosage	How often