Your health insurer requires us to obtain your complete prior medical history. Thank you for filling this out completely.

Name: _____ Height: _____ Weight: _____

List all medications that you are taking, including eye medications: _____

_____

Are you allergic to any medication: Yes ___ No ___ If yes, please list: _____

_____

Please check if you have been diagnosed with/treated for any of the following:

EYES:

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment/Hole
- ☐ Amblyopia/Lazy Eye
- ☐ Strabismus/Crossed Eyes
- ☐ Uveitis/Iritis
- ☐ Eye Injury
- ☐ Other_____

GENERAL:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Thyroid Disease
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ High Cholesterol
- ☐ Migraines
- ☐ Arthritis
- ☐ Hard of Hearing

- ☐ Allergies
- ☐ Sinus Problems
- ☐ Depression/Anxiety
- ☐ Psychiatric Disorder
- ☐ Stroke
- ☐ Limited mobility
- ☐ Cancer/Lymphoma
- ☐ Parkinson's
- ☐ Dementia
- ☐ Other_____

Have you had any eye surgery, laser, or other ocular procedure: Yes____ No____

If yes, please explain_____

Are you a contact lens wearer: Yes____ No____ Am interested____

Please check if you have a: □ Pacemaker □ Defibrillator

Please check if you have had: □ Chemotherapy □ Radiation

Women: Are you pregnant or nursing: Yes____ No____

Men: Have you ever taken Flomax or related prostate medication: Yes____ No____

Do you smoke or have you ever smoked: Yes____ No____ If yes, ____packs per day for ____ years.

Do you drink alcohol: Yes____ No____ If yes, ____drinks per week.

If employed, how many hours do you work each week: ____ hours.

Are there members of your family with:

Glaucoma:	Yes____	No____	Don't know____
Macular degeneration:	Yes____	No____	Don't know____
Retinal detachment:	Yes____	No____	Don't know____
Diabetes:	Yes____	No____	Don't know____