MEDICAL INFORMATION

PATIENT'S NAME: ______________________ **DATE:** __________

DRUG ALLERGIES: ______________________

CURRENT MEDICATIONS: ______________________

MAJOR OPERATIONS: ______________________

CURRENT VISUAL COMPLAINTS: ______________________

HISTORY	PATIENT HISTORY YES	PATIENT HISTORY NO	COMMENTS	FAMILY HISTORY YES	FAMILY HISTORY NO	COMMENTS
CATARACTS						
GLAUCOMA						
CROSSED EYES						
LAZY EYE						
BLINDNESS						
RETINAL PROBLEMS						
EYE INJURY						
EYE SURGERY						
RECENT FLASHES/FLOATERS						
DISTORTION						
PERIPHERAL VISION LOSS						
DOUBLE VISION						
ARE ACTIVITIES IMPAIRED VISUALLY?						
DIABETES						
HIGH BLOOD PRESSURE						
HEART DISEASE						
STROKE						
VASCULAR DISEASE						
GASTROINTESTINAL						
KIDNEY/URINARY TRACT DISEASE						
NEUROLOGICAL						
EMPHYSEMA OR ASTHMA						
CANCER						
TUBERCULOSIS						
BLOOD TRANSFUSION						
OTHER MEDICAL CONDITIONS						
DRUG/ALCOHOL USE						
TOBACCO USE						