Name: _____ Date: _____

***Please answer the following questions about your medical status and history:***

1. Have you ever been treated for any medical conditions (e.g.: diabetes, high blood pressure, arthritis, etc.)?
   Yes ❑ No ❑ If YES, please explain:_____
2. Have you ever had any eye disease (e.g.: glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?
   Yes ❑ No ❑ If YES, please explain:_____
3. Have you ever had any major surgery?
   Yes ❑ No ❑ If YES, please provide date and reason: _____
   _____
4. Have you ever been hospitalized recently? (last 5 years)
   Yes ❑ No ❑ If YES, please provide date and reason: _____
   _____
5. Have you had any eye surgery?
   Yes ❑ No ❑ If YES, please list: _____
6. Do you take any medications, including eyedrops?
   Yes ❑ No ❑ If YES, please list: _____
7. Do you have any drug or food allergies?
   Yes ❑ No ❑ If YES, please list: _____
   _____
8. Do you currently wear contact lenses or would you like to? Yes ❑ No ❑

| ***Review of systems*** | Yes | No | If YES, please explain: |
|---|---|---|---|
| Do you currently have any of the following problems? | | | |
| Chronic fever, unexpected weight loss/gain, fatigue | ❑ | ❑ | _____ |
| Ear/nose/throat problems (e.g.: hearing loss, sinus problems, sore throat)? | ❑ | ❑ | _____ |
| Heart problems (e.g.: chest pain, irregular heart beat)? | ❑ | ❑ | _____ |
| Urinary problems (e.g.: pain, or discomfort, blood in urine)? | ❑ | ❑ | _____ |
| Skin problems (e.g.: rashes, excessive dryness)? | ❑ | ❑ | _____ |
| Musculoskeletal problems (e.g.: muscle aches, joint pain, swollen joints)? | ❑ | ❑ | _____ |
| Neurologic problems (e.g.: numbness, weakness, headaches, paralysis)? | ❑ | ❑ | _____ |

9. Do any medical or eye diseases run in your family (e.g.: diabetes, high blood pressure, cancer, glaucoma, macular degeneration)
   Yes ❑ No ❑If YES, please explain: _____
   _____
10. Do you smoke? If YES, how much?_____drink alcohol? If YES, how much? _____

Comments: _____
_____
_____

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