NAME:_____DOB:_____DATE:_____

OCULAR HISTORY

Do you take AREDS2 eye vitamins? YES NO
Do you take any other eye vitamins? YES (Please List)_____NO
Please list any Eye Drops you are CURRENTLY using and **SPECIFY WHICH EYE.**

_____
_____
_____
_____

Previous Eye Surgeries:

_____
_____

Previous Eye Trauma:

_____

Other Eye Diseases:

_____

MEDICAL HISTORY

Have you had your Flu Vaccine this season? YES NO Date: _____
Have you had a Pneumonia Vaccine within the last 5 years? YES NO Date:_____

Do you have Diabetes?

- ❑ TYPE I
- ❑ TYPE II

Approximate Year Diagnosed:_____Last Hemoglobin A1C:_____
Physician Managing Diabetes:_____

Please check all that apply:

- ❑ Seasonal Allergies
- ❑ Asthma
- ❑ Thyroid Disease
- ❑ Acid Reflux
- ❑ High Blood Pressure
- ❑ Elevated Cholesterol
- ❑ Arthritis
- ❑ Hearing Loss
- ❑ Cancer
- ❑ History of Stroke
- ❑ History of Heart Attack
- ❑ COPD

Other Medical Conditions not listed above:

_____
_____
_____

SURGICAL HISTORY

Please list any prior surgeries and dates below:

_____
_____
_____
_____

NAME:_____DOB:_____DATE:_____

MEDICATIONS

Preferred Pharmacy:_____

Do you take a blood thinner? YES NO

- ❑ Aspirin
- ❑ Xarelto/Rivaroxaban
- ❑ Eliquis/Apixaban
- ❑ Warfarin/Coumadin
- ❑ Other:_____

Please list ALL medications and vitamins you are CURRENTLY taking with dosages and instructions.

_____
_____
_____
_____
_____
_____
_____

Drug Allergies:

Are you allergic to Iodine? YES NO Are you allergic to LATEX? YES NO

Other:_____
_____

FAMILY HISTORY

- ❑ Blindness Relationship:_____
- ❑ Retinal Detachment Relationship:_____
- ❑ Macular Degeneration Relationship:_____
- ❑ Glaucoma Relationship:_____
- ❑ Diabetes Relationship:_____
- ❑ Cancer Relationship:_____
- ❑ Stroke Relationship:_____
- ❑ Heart Disease Relationship:_____

SOCIAL HISTORY

Are You:

- ❑ Not Working/Disabled
- ❑ Retired
- ❑ Working

Occupation:_____

Tobacco Use:

- ❑ NEVER SMOKER
- ❑ CURRENT SMOKER
- ❑ FORMER SMOKER

Date Quit:_____

Alcohol Use:

- ❑ NONE
- ❑ Occasional/Social
- ❑ 1-2 Drinks Daily
- ❑ 3-4 Drinks Daily

Illicit Drug Use: YES NO If Yes, Please Explain:_____

Are you pregnant or trying to conceive? YES NO

Have you been exposed to a Sexually Transmitted Infection? YES NO _____