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

1) What is the reason for your visit today?_____
_____

2) Have you ever been treated for any medical conditions:(diabetes, high blood pressure, arthritis, etc)?
Yes_____No_____. If **YES**, please explain:_____
_____

3) Have you ever had ANY type of surgery?_____
_____

4) Do you have any DRUG or FOOD allergies? Yes___No___ If **YES**, please list:_____
_____

5) What Prescribed Medications are you taking?_____
_____

6) Have you ever had any **EYE DISEASE**:(glaucoma, cataract, wandering eye/lazy eye, retinal disease/detachment)?_____
_____

7) Do any medical or eye diseases run in **YOUR** Family:(diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?_____
_____

8) Do you smoke? If Yes, how much?_____Drink Alcohol? If Yes, how much?_____

9) When was your last eye exam?_____
Where?_____ By Whom?_____
Do you CURRENTLY wear contacts/glasses/both?_____
If Contacts, what type and brand:_____For how long?:_____
If you do not currently wear contacts, would you be interested in a color/clear trial pair?_____

**REVIEW OF SYSTEMS**

| **Do you currently have any of the following problems?** | **Yes/No** | **If Yes, Explain** |
|---|---|---|
| Chronic fevers, unexpected weight loss/gain, fatigue: | Y/N | |
| Ear/nose/throat problems (hearing loss, sinus problems, sore throat) | Y/N | |
| Heart problems (chest pain, irregular heart beat) | Y/N | |
| Respiratory problems (shortness of breath, wheezing, coughing) | Y/N | |
| Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomiting) | Y/N | |
| Urinal problems (pain or discomfort, blood in urine) | Y/N | |
| Skin problems (rashes, excessive dryness) | Y/N | |
| Musculoskeletal problems (muscle aches, joint pain ,swollen joints) | Y/N | |
| Neurological problems (numbness, weakness, headaches, paralysis) | Y/N | |
| Psychiatric problems (depression, anxiety) | Y/N | |

_____ _____
**PLEASE SIGN NAME** **DATE**