

Name _____ Birth date _____ Appt Date ____ - ____ -2012

Family Doctor _____ Vision Assoc. Doctor @ next appt _____

Please circle all that apply to the patient:

Cancer: type _____

Type 1 Diabetes Type 2 Diabetes Graves Disease Hyper/Hypo Thyroid

Decreased Hearing Vertigo

CHF/heart failure Hypertension MI/heart attack High Cholesterol

Crohn's disease Inflammatory bowel disease Reflux

Asthma COPD Emphysema Sleep apnea

Alzheimer's Dementia Migraine MS

Myasthenia gravis Parkinson's Stroke when? _____ TIA when? _____

Renal failure Dialysis Enlarged prostate Kidney stones

Arthritis Fibromyalgia Lupus Rheumatoid arthritis

Acne Rosacea Eczema

Other: _____

Please list your past surgeries with the year of procedures:

Eye surgeries _____

Other surgeries _____

Do you smoke? Yes No

If yes, do you smoke everyday? Yes No Packs per day? _____

Do you chew tobacco? Yes No

Do you drink alcohol? Yes No

Occupation: _____

Marital status: Single Married Divorced Widowed

Please circle all diseases that apply to the patient's family members:

Cancer: type _____

Diabetes Hypertension Thyroid MS Heart disease

Glaucoma _____ Macular Degeneration _____

No family history known Adopted

Please turn over

