PATIENT MEDICAL INFORMATION SHEET			
PATIENT NAME		**DATE OF BIRTH**	
REASON FOR VISIT? *(INLUDE EYE(S) INVOLVED & DURATION OF SYMPTOMS)*			

OCULAR HISTORY			
GLASSES	☐BIFOCALS ☐PROGRESSIVE ☐SINGLE VISION	**CURRENT GLASSES PRESCRIPTIONN**	YRS OLD
CONTACTS	☐SOFT ☐RGP BRAND:	**AVERAGE WEARTIME:**	MIN/ HRS
OCULAR SURGERIES:			

CURRENT EYE DROPS		
1.	☐RIGHT ☐LEFT ☐BOTH	TIMES PER DAY
2.	☐RIGHT ☐LEFT ☐BOTH	TIMES PER DAY
3.	☐RIGHT ☐LEFT ☐BOTH	TIMES PER DAY

CURRENT MEDICATIONS *(OTHER THAN EYE MEDICATIONS)*	
1.	**4.**
2.	**5.**
3.	**6.**

ALLERGIES TO MEDICATIONS? ☐Yes ☐No	*IF YES, PLEASE LIST.*

MEDICAL REVIEW OF SYMPTOMS *(CHECK ALL THAT APPLY)*		
☐**ARRHYTHEMIA**	☐**HYPERTENSION**	☐**THYOID**
☐**STROKE**	☐**SEIZURE**	☐**ARTHRITIS**
☐**CANCER**	☐**ANGINA**	☐**OSTEOPOROSIS**
☐**ASTHMA**	☐**HEART ATTACK**	☐**ANEMIA**
☐**EMPHYSEMA**	☐**BLEEDING TENDANCY**	☐**HIV +VE**
☐**DIABETES;** what was your last HbA1C________and Glucose________	☐**CONGESTIVE HEART FAILURE**	☐**GASTROINTESTINAL**

DO YOU SMOKE? ☐Yes ☐No	*IF YES, HOW OFTEN?*	**DO YOU DRINK ALCOHOL?**☐Yes ☐No	*IF YES, HOW OFTEN?*

FAMILY HISTORY*(NOT INNCLUDING YOURSELF, CHECK ALL THAT APPLY)*		
☐ **RETINAL DETACHMENT**	**RELATIONSHIP**	
☐ **MACULAR DEGNERATION**	**RELATIONSHIP**	
☐ **GLAUCOMA**	**RELATIONSHIP**	
☐ **CATARACT**	**RELATIONSHIP**	
☐ **DIABETES**	**RELATIONSHIP**	