Medical History

(This information is kept confidential)

Name: _____

Do you have any allergies to medications? ☐No ☐Yes If yes, list and explain

_____

Do you take any medications? (Including oral contraceptives over the counter medications and home remedies):

☐No ☐Yes If yes please list:_____

_____

_____

_____

Medical Information Do **you** currently have any problems in the following areas?
(**Circle yes or no for each condition**)

DIABETES	YES	NO	ALLERGIES/HAY FEVER	YES	NO
HIGH BLOOD PRESSURE	YES	NO	ELEVATED CHOLESTEROL	YES	NO
HEART DISEASE	YES	NO	ELEVATED TRIGLYCERIDES	YES	NO
ARTHRITIS	YES	NO	GLAUCOMA	YES	NO
THYROID DISEASE	YES	NO	CATARACT	YES	NO
ASTHMA	YES	NO	MACULAR DEGENERATION	YES	NO
RHEUMATOID ARTHRITIS	YES	NO			
HEADACHES	YES	NO	EYE INJURIES	YES	NO
EYE SURGERY	YES	NO			

If you answered yes to any of the above or have a condition not listed, please explain

_____

_____

_____

Family History Please note any **family history** for the following conditions? (**Circle yes or no for each condition)**

DISEASE/CONDITION			If History in family list relationship to you
DIABETES	YES	NO	_____
GLAUCOMA	YES	NO	_____
CATARACT	YES	NO	_____
MACULAR DEGENERATION	YES	NO	_____
HEART DISEASE	YES	NO	_____

Do you drive? ☐No ☐Yes if yes, do you have visual difficulty when driving? □ No □ Yes

If yes, please describe_____