Past Ocular/Medical History

Name:_____ **DOB:**_____

Allergies: _____

Past Ocular History

_____
_____
_____
_____

Past Ocular Surgeries

_____
_____
_____
_____

Current Eye Medications

_____
_____
_____
_____

Past Medical History

_____
_____
_____
_____

Past Surgeries

_____
_____
_____
_____

Current Systemic Medications

_____
_____
_____
_____

Family History: **P = Parent** **S = Sibling** **G = Grandparent**

Cataract	**P**	**S**	**GP**	High Blood Pressure	**P**	**S**	**GP**	Stroke	**P**	**S**	**GP**
Glaucoma	**P**	**S**	**GP**	Heart Disease	**P**	**S**	**GP**	Other: _____			
Macular Degeneration	**P**	**S**	**GP**	Cancer	**P**	**S**	**GP**				

Social History:

Smoking Status ☐ YES ☐ NO ☐Quit How long:_____
Alcohol ☐ YES ☐ NO If Yes: How much?_____
Drugs ☐ YES ☐ NO Drugs Used:_____