MEDICAL HISTORY – If you have been treated/experienced any of the following, circle (Yes/No) If family, circle them also.			
Constitutional			
Fever, Weight Loss/Gain	Yes	No	
Cancer	Yes	No	Or Family Member
Ear, Nose, Mouth, Throat			
Dry Throat/Mouth	Yes	No	
Hearing Loss	Yes	No	
Sinusitis	Yes	No	
Neurological			
Seizures/Epilepsy	Yes	No	Or Family Member
Headaches	Yes	No	
Migraines	Yes	No	
Tumor	Yes	No	
Multiple Sclerosis	Yes	No	Or Family Member
Psychiatric			
Anxiety	Yes	No	
Depression	Yes	No	
Other	Yes	No	
Respiratory			
Asthma	Yes	No	
Sleep Apnea	Yes	No	
Emphysema	Yes	No	
Chronic Bronchitis	Yes	No	
Allergic/Immunologic			
Seasonal Allergies	Yes	No	
Sjogren's Syndrome	Yes	No	Or Family Member
Lupus	Yes	No	Or Family Member
Rheumatoid Arthritis	Yes	No	Or Family Member
Gastrointestinal			
Acid Reflux	Yes	No	
Crohn's Disease	Yes	No	Or Family Member
Genitourinary			
Pregnant	Yes	No	
Nursing	Yes	No	
Prostate Disease	Yes	No	
Kidney Disease/Stones	Yes	No	Or Family Member
Musculoskeletal			
Arthritis	Yes	No	
Osteoporosis	Yes	No	
Integumentary (Skin)			
Shingles/Herpes Zoster	Yes	No	
Cold Sores/Herpes Simples	Yes	No	
Psoriasis	Yes	No	
Rosacea	Yes	No	
Endocrine			
Type 1 Diabetes	Yes	No	Or Family Member
Type 2 Diabetes	Yes	No	Or Family Member
Thyroid Dysfunction	Yes	No	Or Family Member
Other Hormonal Dysfunctions	Yes	No	Or Family Member
Lymphatic/Hematologic			
Anemia	Yes	No	
Cardiovascular			
Heart Disease	Yes	No	Or Family Member
High Cholesterol	Yes	No	Or Family Member
Stroke	Yes	No	Or Family Member
High Blood Pressure	Yes	No	Or Family Member

GLASSES/CONTACT LENS HISTORY – Please circle.			
Currently Wear Glasses?	Yes	No	
Currently Wear Contacts?	Yes	No	
Type of Contact Lenses	Soft	Rigid	Extended Wear
	Other		

EYE HISTORY - If you have been treated/experienced any of the following, circle (Yes/No) If family, circle them also.			
Cataracts	Yes	No	Or Family Member
Crossed Eye	Yes	No	Or Family Member
Glaucoma	Yes	No	Or Family Member
Retinal Detachment	Yes	No	Or Family Member
Lazy Eye	Yes	No	Or Family Member
Macular Degeneration	Yes	No	Or Family Member
LASIK or PRK	Yes	No	

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

	Burning		Eye Infection
	Double Vision		Floaters or Spots
	Excess Tearing/Watering		Discharge
	Eye Pain or Soreness		Dryness
	Halos		Headaches
	Itching		Redness
	Light Flashes		Light Sensitivity
	Sandy or Gritty Feeling		
	Blurry Vision *Near or Distance*		

ALLERGIES		
Do you have any allergies to any medications? Explain.	Yes	No

SURGERIES

MEDICATIONS – List any medications you are currently taking (include oral contraceptives, aspirin, over-the-counter medication, & home remedies).