Patient Name: Date of Birth:

Medical History and Review of Systems

Do you have a history of:

Glaucoma ◯ Yes ◉ No
Cataracts ◯ Yes ◉ No
Lens Implant ◯ Yes ◉ No
Retinal Detachment ◯ Yes ◉ No
Lazy Eye (Amblyopia) ◯ Yes ◉ No
Corneal Transplant ◯ Yes ◉ No
Other Eye Injuries ◯ Yes ◉ No
Please explain any 'Yes' answers:

Do you have a family history of:

Glaucoma ◯ Yes ◉ No
Cataracts ◯ Yes ◉ No
Retinal Detachment ◯ Yes ◉ No
Blindness ◯ Yes ◉ No
Diabetes ◯ Yes ◉ No

Are you currently using eye drops? ◯ Yes ◉ No

Please list:

Please list any medications you are taking:

Medication	Dosage	Frequency

Please list any eye surgery you have had:

Do you have or have you ever had any of the following:

Diabetes ◯ Yes ◉ No
High Blood Pressure ◯ Yes ◉ No
Heart Disease or Angina (Chest Pain) ◯ Yes ◉ No
Liver Disease ◯ Yes ◉ No
Hepatitis or Yellow Jaundice ◯ Yes ◉ No
Kidney Stones or Failure ◯ Yes ◉ No
Stroke or Paralysis ◯ Yes ◉ No
Rheumatoid Arthritis ◯ Yes ◉ No
Cancer ◯ Yes ◉ No
Thyroid Issues ◯ Yes ◉ No
Please explain any 'Yes' answers:

Please list any other surgeries you have had:

Please list any other medical conditions:

Are you allergic to any medications? ◯ Yes ◉ No
Please list:

Signature: Date: