Name: _____ Chart #_____ Date _____

Date of Birth: _____Age_____ S.S. #_____-____-_____

Marital Status:(Single, Married ,Widowed,Divorced,Separated) Employed: (Yes, No, Retired, Student)_____

Conditions you have now or have had in the past, or family member (Mother-Father-Siblings-GrandParent)	Yes	No	If yes, please identify	Date of condition	Family? Yes	No	Relation M	F	S	C
General/Constitution										
Ears, Nose, Throat										
Cardiovascular										
Respiratory										
Gastrointestinal										
Genital, Kidney, Bladder										
Females: (Are you pregnant or Nursing)										
Muscles, Bones, Joints										
Skin										
Neurological										
Psychiatric										
Endocrine										
Blood/Lymph (bleeding, high cholesterol, anemia, probs. related to blood transfusions)										
Allergic/Immunologic										
Cancer: EYES (Cataract, Glaucoma, Detached Retina, Blindness, Lazy Eye, Eye injury, Cornea Problems)										

Tobacco: ___ Yes ___ No ____ Seldom ___Frequent

List any Drug Allergies: _____

Drugs: ___ Yes ___ No ____ Seldom ___Frequent

_____

Alcohol: ___ Yes ___ No ____ Seldom ___Frequent _____

Any Surgeries other than eye surgeries you have had in the past three years_____

_____

Any Eye or Laser surgeries you have had.

_____

_____