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:______________________