**MEDICAL PROBLEMS:**

Circle problems that you have had.

- None
- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation (Irregular Heartbeat)
- Bone Marrow Transplantation
- Benign Prostatic Hypertrophy (BPH)
- Breast Cancer
- Colon Cancer
- Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- Esophageal Reflux (GERD)
- Hearing Loss
- Hepatitis
- Hypertension
- HIV / AIDS
- Hypercholesterolemia
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- Other

**PAST SURGERIES:**

Circle surgeries that you have had.

- None
- Appendix (Appendectomy)
- Bladder (Cystectomy)
- Breast: Breast Biopsy
- Breast: Lumpectomy: Right; Left; Both
- Breast: Mastectomy: Right; Left; Both
- Colon (Colectomy): Colon Cancer Surgery
- Colon (Colectomy): Diverticulitis
- Colon (Colectomy): Inflammatory Bowel Disease
- Colon: Colostomy
- Gallbladder (Cholecystectomy)
- Heart: Biological Valve Replacement
- Heart: Coronary Artery Bypass Surgery
- Heart: Heart Transplant
- Heart: Mechanical Valve Replacement
- Heart: PTCA
- Hip Replacement: Right; Left; Both
- Knee Replacement: Right; Left; Both

Kidney: Kidney Biopsy
Kidney: Kidney Stone Removal
Kidney: Kidney Transplant
Kidney: Nephrectomy
Liver: Hepatectomy
Liver: Liver Transplant
Liver: Shunt
Ovaries (Oophorectomy) Endometriosis
Ovaries (Oophorectomy) Ovarian Cancer
Ovaries (Oophorectomy) Ovarian Cyst
Ovaries: Tubal Ligation
Pancreas: Pancreatectomy
Prostate (Prostatectomy) Prostate Biopsy
Prostate (Prostatectomy) Prostate Cancer
Prostate (Prostatectomy) Transurethral Resection (TURP)
Rectum: Anterior-Posterior Resection (APR)
Rectum: Low Anterior Resection
Skin: Basal Cell Carcinoma
Cheek with Mose procedure
Skin: Melanoma
Skin: Skin Biopsy
Skin: Squamous Cell Carcinoma
Spleen (Splenectomy)
Testicles (Orchiectomy)
Uterus (Hysterectomy) Fibroids
Uterus (Hysterectomy) Uterine Cancer
Uterus (Hysterectomy) Cervical Cancer
Other

Please complete both sides of this form.
## OCULAR HISTORY

**Circle problems that you have had.**

None

- Allergic Conjunctivitis
- Blepharitis
- Cataract: Right; Left; Both
- Contact Lenses: Right; Left; Both
- Corneal Dystrophy: Right; Left; Both
- Background Diabetic Retinopathy: Right; Left; Both
- Proliferative Diabetic Retinopathy: Right; Left; Both
- Dry Eyes
- Glasses
- Glaucoma: Right; Left; Both
- Macular Degeneration: Right; Left; Both
- Macular Membrane (ERM): Right; Left; Both
- Narrow Angles: Right; Left; Both
- Ocular Hypertension: Right; Left; Both
- Ophthalmic Migraine
- Pseudoexfoliation
- Retinal Tear: Right; Left; Both
- Strabismus
- Vitreous Detachment: (PVD): Right; Left; Both
- Vitreous Floaters: Right; Left; Both

**Primary Care Physician Name and Phone #**

### Height ________

### Weight ________

## OCULAR SURGERY

**Circle surgeries that you have had.**

None

- Blepharoplasty: Right; Left; Both
- Cataract Surgery: Right; Left; Both
- Corneal Transplant: Right; Left; Both
- DSAEK: Right; Left; Both
- Eye Muscle Surgery: Right; Left; Both
- Intravitreal Injections: Right; Left; Both
- LASIK: Right; Left; Both
- LPI: Right; Left; Both
- Laser glaucoma surgery (LTP): Right; Left; Both
- Photo Refractive Keratoplasty (PRK): Right; Left; Both
- Ptosis Repair: Right; Left; Both
- Punctal Plugs: Right; Left; Both
- Strabismus Surgery
  - Retinal Laser: Right; Left; Both
  - Trabeculectomy: Right; Left; Both
  - Tube Shunt: Right; Left; Both
  - Yag Capsulotomy: Right; Left; Both
- Other __________________________

## MEDICATION LIST: (Includes Drops)

### ALLERGIES (Including Medications):

| __________________________ |
| __________________________ |
| __________________________ |
| __________________________ |

## SMOKING HISTORY (please circle):

- Never
- Smoked but has stopped
- Smoking

## DAILY ALCOHOL CONSUMPTION (please circle):

- NONE
- < 1 Drink Daily
- 1-2 Drinks Daily
- > 3 Drinks Daily_________ (please list)

## FAMILY HISTORY OF ILLNESSES:

**Mother:**

| __________________________ |

**Father:**

| __________________________ |

**Brother/Sisters:**

| __________________________ |