Has anyone in your **FAMILY** had: (If yes, explain)

Yes/No Glaucoma_____

Yes/No Cataracts_____

Yes/No Blindness_____

Yes/No Other Eye Diseases_____

Yes/No Diabetes_____

Yes/No Macular Degeneration_____

Yes/No Hypertension_____

Do You Use: How Often?

Yes/No Tobacco _____

Yes/No Drugs _____

Yes/No Alcohol _____

Have you ever had any **Eye Surgery**? Yes/No

Please List: _____

_____

Past Anesthetic Complications

_____

Have you ever had **General Surgeries**? Yes/No

Please List:

_____

Please List any medications you are currently taking or have taken over the past six months, including eye drops:

MEDICATION NAME	REASON TAKEN	CURRENTLY TAKING

PATIENT SIGNATURE_____ **BIRTHDAY** _____

For Office Use Only

Reviewed_____ Date_____ Reviewed_____ Date_____

Reviewed_____ Date_____ Reviewed_____ Date_____