Druid Hills Eye Care Medical History

Name: _____ Date: _____

Family Physician: _____

General History

Do you have a history of or are currently under treatment for (please circle):

High Blood Pressure	Yes	No	**Cancer**	Yes	No
Heart Disease	Yes	No	**Arthritis**	Yes	No
Diabetes	Yes	No	**Lupus**	Yes	No
Asthma	Yes	No	**Rosacea**	Yes	No
High Cholesterol	Yes	No	**Thyroid (Low/High)**	Yes	No
Stroke	Yes	No	**Emphysema**	Yes	No
Seizures	Yes	No	**Headache/Migraine**	Yes	No

Do you smoke? None <1pack/day 1-2 packs/day Former Smoker

Do you drink alcohol? None Socially 1-2 drinks/day >2 drinks/day

Do you use illegal drugs? Yes No If yes, please list type/amount/how long: _____

Other (please list): _____

Eye Health

Have you ever been treated for or are currently experiencing any of the following (please circle):

Cataracts	Yes	No	**Macular Degeneration**	Yes	No
Eye Injuries	Yes	No	**Retinal Detachment**	Yes	No
Eye Surgery	Yes	No	**Lazy Eye (Amblyopia)**	Yes	No
Glaucoma	Yes	No	**Flashes or Floaters**	Yes	No

Other (please list): _____

Family History

Please list all family members (parents, grandparents, brothers, sisters) who have or have had any of the following disorders:

Diabetes: _____ **Macular Degeneration:** _____

Cancer: _____ **Glaucoma:** _____

Heart Disease: _____ **Blindness:** _____

High Blood Pressure: _____ **High Cholesterol:** _____

Other Diseases that run in your family: _____

Please list all medications you are currently taking: _____

_____

_____

Are you allergic to any medications (please circle): Yes No

Please list all medications you are allergic to and include the **reaction** to each: _____

_____