FAMILY MEDICAL HISTORY
CIRCLE FAMILY MEMBER AFFECTED BY:

CANCER	Father	Mother	Brother	Sister	Son	Daughter	Unknown
DIABETES Please note Type 1 or Type 2 if known	Father	Mother	Brother	Sister	Son	Daughter	Unknown
HIGH BLOOD PRESSURE	Father	Mother	Brother	Sister	Son	Daughter	Unknown
HEART DISEASE/ STROKE	Father	Mother	Brother	Sister	Son	Daughter	Unknown
THYROID DISEASE	Father	Mother	Brother	Sister	Son	Daughter	Unknown

FAMILY OPTICAL HISTORY
CIRCLE FAMILY MEMBER AFFECTED BY:

CATARACTS	Father	Mother	Brother	Sister	Son	Daughter	Unknown
MACULAR DEGEN.	Father	Mother	Brother	Sister	Son	Daughter	Unknown
RETINAL DETACHMENT	Father	Mother	Brother	Sister	Son	Daughter	Unknown

YOUR PAST OPTICAL HISTORY
CIRCLE ALL THAT APPLY

CATARACTS **CATARACT SURGERY** Date:

INJURY Date: **DRY EYE**

RETINAL DETACHMENT/ TEARS/HOLES **GLAUCOMA**

MACULAR DEGENERATION **LASIK**

AMBLYOPIA **PATCHING**

KERATOCONUS **EYE MUSCLE SURGERY** Date:

SOCIAL HISTORY

Do you drink alcohol? **No** _____ **Yes**_____

If yes, please circle one:

Occasionally 1-2/Day 3 +/Day

Do you use tobacco? **No** _____ **Yes** _____

If yes, which types? Cigarettes Cigars/Pipe Chew

How much usage? ____________________

Do you have any hobbies or special visual needs?

No _____ **Yes** _____

If yes, please list: