Medical Review

Date:

Name: _____ Age:_____

Occupation: _____

Primary Care Doctor: _____

Medications: _____

_____

_____

Medication Allergies: _____

Eye Problems (circle those that apply):

Injury
Surgery
Contact Lens Wear
Glaucoma
Cataract
Retinal Detach/ Degeneration

Medical Problems (circle those that apply):

Heart Disease or Surgery
High Blood Pressure

Asthma or Emphysema
Diabetes

Cancer:

Headache
Migraine
Stroke
Depression
HIV
Hepatitis
Ulcer
Thyroid
Arthritis
Lupus
Sjogren's
Roseacea

Smoke
Drink Alcohol
Nonprescription Medications

Family History of:
Glaucoma
Retinal Detachment
Macular Degeneration
