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EYE MD MONTEREY

Patient Name **Date of Birth** **Date**

GENERAL MEDICAL HISTORY

Please indicate if any of the following apply to your general medical history:

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Transfusion
- ☐ Breast Cancer
- ☐ Cancer, colon
- ☐ Cancer, lung
- ☐ Cancer, skin
- ☐ Cancer, Other
- ☐ COPD
- ☐ Congestive heart failure
- ☐ Dementia
- ☐ Diabetes ◯ Type 1 ◯ Type 2
- ☐ Elevated Cholesterol
- ☐ Heart Attack
- ☐ HIV
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Pacemaker
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Other: _____

Past Surgeries: _____

_____

FAMILY HISTORY

Please indicate if any of the following apply to your family history:

☐ Family history unknown

Eye Problems:

- ☐ Blindness
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Corneal Disease
- ☐ Keratoconus
- ☐ Corneal transplant
- ☐ Macular degeneration
- ☐ Diabetic Retinopathy
- ☐ Retinal Detachment
- Retinitis Pigmentosa
- ☐ Other eye problems: _____

_____

_____

Medical Problems:

- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid
- ☐ Hypertension
- ☐ Stroke
- ☐ Heart Disease

Other Health Condition:

_____

_____

SOCIAL HISTORY

Occupation:

Important vision-related activities:

_____

_____

Does your vision limit activities of daily living (driving, reading, sports, work, etc.)? ◯ Yes ◯ No

_____

_____

	YES	NO
Do you drink alcohol?	◯	◯
If YES, how much? _____		
Do you smoke?	◯	◯
If YES, how much? _____		
Did you smoke in the past?	◯	◯
For how many years? _____		