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Denton R. Roberts, M.D. / James B. Earl, M.D., Ph.D.

HISTORY FORM- CONFIDENTIAL

Name:____

What problem(s) brought you to clinic today? ____________________________

Allergies (Medicine):____________________________________

Current Medications:____________________________________

Past Ocular History:____________________________________

Past Medical History:___________________________________

Past Surgical History:___________________________________

Family History:

Ocular Condition:	Relationship:	Medical Condition:	Relationship:

Do you smoke? (Circle one) Y N Formerly How much? ________ How long? ________

Do you use alcohol? Y N How much? _________How often?______________

Do you drink caffeine? Y N How much per day?____________________

Do you use recreational drugs? (Circle one) Y N Formerly