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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: |
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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