NAME:_____ DOB:_____ DATE: _____

Please complete all areas, indicate N/A if not applicable

With or without your glasses on do you have problems/difficulty seeing to: Drive? Y N Read? Y N

Watch TV? Y N Work? Y N Hobbies? Y N Other: _____

Hearing difficulty Y N Nasal/Sinus Problems Y N Difficulty Swallowing/Throat Problems Y N

High Blood Pressure Y N High Cholesterol Y N Other Heart Problems _____

Asthma Y N Breathing difficulty Y N Chronic Cough Y N
Other Respiratory Problems: _____

Hiatal Hernia Y N Reflux Y N Ulcer Y N Bowel/Colon Problem Y N Describe: _____
Other Stomach Problems: _____

Prostate Problem Y N Incontinence Y N Kidney Problem Y N Describe: _____

Arthritis Y N Where? _____ Use a Cane Y N Wheel Chair Y N

Depression Y N Anxiety Y N Memory Loss Y N Mental Illness Y N

Diabetes Y N How Long: _____ Thyroid Problem Y N

Anemia Y N Blood Problem Y N Describe: _____

Any Viral Illnesses? ie. Herpes, Hepatitis, HIV, TB?_____

Have you ever had any type of cancer? Y N Describe: _____

Do you smoke? Y N qty: _____ Drink alcohol? Y N qty: _____ Use Caffeine Y N qty: _____

Do you live alone? Y N Do you have someone to help you if needed? Y N

Family History: Glaucoma Y N Macular degeneration Y N Cancer Y N

Diabetes Y N Heart condition Y N Describe: _____

Have you ever had any surgery? Y N please list: _____

_____

Are you allergic to any medications? Y N please list all allergies: _____

_____

Please list all current medications, including over-the-counter meds and eye meds: _____

_____

Regular Medical Doctor:_____ Phone:_____

Address:_____

Any other medical information we should have? _____