

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Yes/No**

- Lung Disease - Type: \_\_\_\_\_
- Kidney Disease: \_\_\_\_\_
- Arthritis: \_\_\_\_\_
- Diabetes: \_\_\_\_\_ # of Yrs.: \_\_\_\_\_
- Neurological Disease: \_\_\_\_\_
- Migraines: \_\_\_\_\_
- Psychiatric Disorder: \_\_\_\_\_
- Prostate Disorder: \_\_\_\_\_
- Have you ever taken medicine for this disorder?  
Type: \_\_\_\_\_
- Nervous Disorder: \_\_\_\_\_
- Heart Disease: \_\_\_\_\_
- Gastrointestinal Disease:  
Type: \_\_\_\_\_
- High Blood Pressure: \_\_\_\_\_ # of Yrs.: \_\_\_\_\_
- Scarring/Keloids: \_\_\_\_\_
- Are you allergic to Latex, Rubber? \_\_\_\_\_

**Yes/No**

- Head or Spinal Injuries: \_\_\_\_\_
- Seizures, Convulsions, Fainting: \_\_\_\_\_
- Temporal Arteritis: \_\_\_\_\_
- Carotid Artery Disease: \_\_\_\_\_
- (Women) Are you pregnant or nursing? \_\_\_\_\_
- Stroke: \_\_\_\_\_
- HIV/AIDS: \_\_\_\_\_ # of Yrs.: \_\_\_\_\_
- Extensive Confinement from Illness, Disease or Injury:  
\_\_\_\_\_
- Permanent Defect from Illness, Disease or Injury:  
\_\_\_\_\_
- Do you smoke? #Packs per \_\_\_ Day \_\_\_ Week \_\_\_ Month \_\_\_
- Do you drink? #per \_\_\_ Day \_\_\_ Week \_\_\_ Month
- Are you allergic to Bananas, Pears, Avocado, Chestnuts?
- Do you live alone?

**Your Medical Doctor:** \_\_\_\_\_

**Please List All Medications You Are Currently Taking:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please List All Medication Allergies:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have You Been Diagnosed With or Treated for Any of the Following:**

**Yes/No**

- Cataracts
- Crossed Eyes
- Retinal Disease: \_\_\_\_\_
- Injury: \_\_\_\_\_
- Cataract Surgery Date: \_\_\_\_\_ Right Eye
- Do you have a lens implant:  Yes  No
- Other Eye Surgery Date: \_\_\_\_\_ Right Eye
- Type of Eye Injury (if any): \_\_\_\_\_

**Yes/No**

- Corneal Disease: \_\_\_\_\_
- Glaucoma
- Iritis
- Other Eye Disorders: \_\_\_\_\_
- Cataract Surgery Date: \_\_\_\_\_ Left Eye
- Cataract Surgery Date: \_\_\_\_\_ Left Eye

**Has Any Family Member (Mother, Father, Sisters or Brothers) Been Treated for the Following:**

**Yes/No**

- Glaucoma: \_\_\_\_\_
- Cataracts: \_\_\_\_\_
- Macular Degeneration: \_\_\_\_\_
- Diabetic Retinopathy: \_\_\_\_\_
- Diabetes: \_\_\_\_\_
- Stroke: \_\_\_\_\_

**Yes/No**

- Retinal Detachment: \_\_\_\_\_
- Corneal Disease: \_\_\_\_\_
- Retinitis Pigmentosa: \_\_\_\_\_
- Other Eye Problems: \_\_\_\_\_
- Heart Disease: \_\_\_\_\_
- Other Health Conditions: \_\_\_\_\_

**Please List Any Previous Surgeries and Their Dates: (Please Continue on Back of Form.)**

\_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_

**Previous Surgeries and Dates:** (Continued)

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