

REVIEW OF MEDICAL HISTORY

Many eye conditions are related to conditions found elsewhere in a person's body. Please help us provide you with the best possible care by completing the following questionnaire. If there is additional information that you feel we should know, please share this with the technician or doctor. Thank you.

Please check if you are being treated for, have **ever** been treated for, or are being **monitored** for any of the following:

	Yes	No	<u>When incident occurred or when diagnosed</u>
Diabetes	_____	_____	_____
High Blood Pressure	_____	_____	_____
Angina or Chest Pain	_____	_____	_____
Irregular Heart Beat	_____	_____	_____
Cardiac Pacemaker	_____	_____	_____
Stroke	_____	_____	_____
Anemia	_____	_____	_____
Allergies	_____	_____	_____
Asthma	_____	_____	_____
Bronchitis	_____	_____	_____
Emphysema / COPD	_____	_____	_____
Pneumonia	_____	_____	_____
Tuberculosis	_____	_____	_____
Liver Disease	_____	_____	_____
Stomach Ulcer	_____	_____	_____
Gastric Reflux	_____	_____	_____
Kidney Stones	_____	_____	_____
Arthritis	_____	_____	_____
Cancer or Tumor Include location and treatment	_____	_____	_____
Thyroid Disease	_____	_____	_____
Seizures	_____	_____	_____
Varicose Veins or Blood clots in legs	_____	_____	_____
Other	_____	_____	_____