



PATIENT NAME: _____

DATE: _____

GENERAL HEALTH INFORMATION SHEET

Please list any medications: _____

Please list any allergies (medical & general): _____

Do any of the following conditions apply to you:

- | | | |
|---|---|--|
| _____ Constitutional (fever, weight change) | _____ Ear/Nose/Mouth/Throat | _____ Skin Condition |
| _____ Stomach or Gastrointestinal | _____ Kidney or Liver | _____ Lung or Respiratory |
| _____ Asthma | _____ Diabetes | _____ Stroke |
| _____ Heart condition/disease | _____ High blood pressure | _____ High cholesterol |
| _____ Psychological | _____ Blood disorder | _____ Headaches |
| _____ Multiple sclerosis | _____ Arthritis or joint | _____ Thyroid |
| _____ Cancer | _____ Immune deficiency | _____ Pregnant |
| _____ Cataracts | _____ Macular degeneration | _____ Glaucoma |
| _____ Lazy eye or eye turn | _____ Retinal detachment | _____ Dry eye |
| _____ Tobacco: <input type="checkbox"/> light <input type="checkbox"/> mod <input type="checkbox"/> heavy | _____ Alcohol: <input type="checkbox"/> light <input type="checkbox"/> mod <input type="checkbox"/> heavy | _____ Drug use: <input type="checkbox"/> light <input type="checkbox"/> mod <input type="checkbox"/> heavy |

If you indicated any of the above conditions apply to you, please explain and list treatment:

Please list any other health conditions:

Does your family history include any of the following? If yes, what is their relationship to you?

- | | |
|------------------------------------|---|
| _____ Glaucoma _____ Relationship: | _____ High Blood Pressure _____ Relationship: |
| _____ Cataracts _____ | _____ Heart Disease _____ |
| _____ Macular Degeneration _____ | _____ Diabetes _____ |
| _____ Retinal Detachment _____ | _____ Thyroid Condition _____ |
| _____ Blindness _____ | _____ Other _____ |

Signature _____

Relationship to patient _____