ANN ARBOR optometry

Primary care physician: _____

Primary care phone: _____

Primary care address: _____

Hobbies, special vision needs: _____

_____

Please list any medications: _____

_____

_____

Height: _____ft. _____in. Weight:_____lbs

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	_____ 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
_____ Eye injury	_____ Eye surgery	_____ Head injury
_____ Tobacco: ☐light ☐mod ☐heavy	_____ Alcohol: ☐light ☐mod ☐heavy	_____ Drug use: ☐light ☐mod ☐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?

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

Signature_____ Relationship to patient _____