ANN ARBOR optometry

Patient Name:____

Primary care Doctor: ____

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)
_____ Stomach or Gastrointestinal
_____ Asthma
_____ Psychological
_____ Multiple sclerosis
_____ Cancer
_____ Cataracts
_____ Lazy eye or eye turn
_____ Eye injury
_____ Tobacco: ☐light ☐mod ☐heavy

_____ Ear/Nose/Mouth/Throat
_____ Kidney or Liver
_____ Diabetes
_____ Blood disorder
_____ Arthritis or joint
_____ Immune deficiency
_____ Macular degeneration
_____ Retinal detachment
_____ Eye surgery
_____ Alcohol: ☐light ☐mod ☐heavy

_____ Skin Condition
_____ Lung or Respiratory
_____ High cholesterol
_____ Headaches
_____ Thyroid
_____ Pregnant
_____ Glaucoma
_____ Dry eye
_____ Head injury
_____ 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 ____________________