Aurora
EYE CLINIC, LTD.

DATE: _____

PATIENT'S NAME: _____

DO YOU CURRENTLY WEAR: glasses contacts Interested in contacts **(Please circle)**

PLEASE CIRCLE ANY OF THE FOLLOWING THAT APPLY TO YOUR MEDICAL HISTORY.

High blood pressure	Brain tumor	Asthma
Heart attack	Headache	Shortness of breath
Heart Disease	Head injury	Emphysema/ COPD
Stroke	Seizures	Ear/Nose/Throat problems
High Cholesterol	Thyroid Disease	Nervous disorder
Pacemaker	Diabetes	Skin disorder
Arthritis	Bowel problems	Cancer
Rheumatoid disease	Ulcer disease	Prostate disease
Kidney disease	Currently pregnant or nursing	Blood disease
Other _____		

Please circle any of the following that apply to your eye history

Blepharitis	Corneal transplant	Cataract
Double vision	Diabetic Retinopathy	Eye injury
Lazy eye	Retinal detachment	Macular Degeneration
Iritis	Glaucoma	LASIK/PRK/RK

Please **list any eye surgeries or laser treatments** you have had in the past _____

_____

Please **list all medications you are taking**:_____

_____

_____

_____

Do you have any **medication allergies/reactions**? Yes No
Please list:_____

Have you ever had **problems with anesthesia**? Yes No

SOCIAL HISTORY:

Alcohol Use: none / rarely / occasional

Tobacco Use: (Cigarettes, Cigars, Chew) current / former / never (circle one)

Years used: _____

Year quit: _____

Caffeine Use: yes / no **How much** _____

Recreational Drug Use yes / no / formerly

DO ANY OF YOUR IMMEDIATE FAMILY MEMBERS HAVE ANY OF THE FOLLOWING: (Please circle)

Diabetes	Glaucoma	Muscle disorders of the eye
Blindness	Macular degeneration	Retinal detachment

Primary Care Doctor: _____ Referred by: _____