



## Chronic Health Conditions:

Please check if you have ever been diagnosed with any of the following

- |   |                                       |  |  |   |
|---|---------------------------------------|--|--|---|
| <input type="checkbox"/> Acid Reflux          | <input type="checkbox"/> A-Fib        | <input type="checkbox"/> Gout                | <input type="checkbox"/> Migraines             | <input type="checkbox"/> Schizoaffective Disorder |
| <input type="checkbox"/> Allergies            | <input type="checkbox"/> Bipolar      | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Mitral Valve Disorder | <input type="checkbox"/> Seizure Disorder         |
| <input type="checkbox"/> Alzheimers Disease   | <input type="checkbox"/> Cancer       | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Multiple Sclerosis    | <input type="checkbox"/> Sickle Cell Trait        |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> COPD         | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Heart Attack          | <input type="checkbox"/> Sinusitis                |
| <input type="checkbox"/> Anxiety              | <input type="checkbox"/> Dementia     | <input type="checkbox"/> HIV                 | <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> Osteoarthritis       | <input type="checkbox"/> Depression   | <input type="checkbox"/> Irritable Bowel     | <input type="checkbox"/> Parkinson Disease     | <input type="checkbox"/> Thyroid                  |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Pneumonia             | <input type="checkbox"/> Ulcerative Colitis       |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Facial Palsy | <input type="checkbox"/> Lupus               | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Vertigo                  |

## Covid Compliance: (please check yes or no)

Have you had Covid? Yes \_\_\_ No \_\_\_ Date: \_\_\_\_\_ Symptomatic \_\_\_ Asymptomatic \_\_\_  
 Hospitalization Required? Yes \_\_\_ No \_\_\_ Admitted to ICU? Yes \_\_\_ No \_\_\_  
 Are you diabetic or immunocompromised? Yes \_\_\_ No \_\_\_ If yes, which one \_\_\_\_\_  
 Have you been vaccinated? Yes \_\_\_ No \_\_\_ Dose 1 \_\_\_ Dose 2 \_\_\_

## Past General Surgeries: Please list any past surgical procedures you have had. (please list any eye surgeries in the previous section labeled "Ocular History")

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## Family History

<u>Condition</u>	<u>Family Member</u>	<u>COD</u>	<u>Condition</u>	<u>Family Member</u>	<u>COD</u>
<input type="checkbox"/> Blindness	_____	<input type="checkbox"/>	<input type="checkbox"/> Heart disease	_____	<input type="checkbox"/>
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/>	<input type="checkbox"/> High blood pressure	_____	<input type="checkbox"/>
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/>	<input type="checkbox"/> Retinal disease	_____	<input type="checkbox"/>
<input type="checkbox"/> Early loss of vision	_____	<input type="checkbox"/>	<input type="checkbox"/> Stroke	_____	<input type="checkbox"/>
<input type="checkbox"/> Glaucoma	_____	<input type="checkbox"/>	<input type="checkbox"/> Migraines	_____	<input type="checkbox"/>
<input type="checkbox"/> Macular Degeneration	_____	<input type="checkbox"/>	<input type="checkbox"/> Alzheimer's Disease	_____	<input type="checkbox"/>
<input type="checkbox"/> Thyroid disease	_____	<input type="checkbox"/>	<input type="checkbox"/> Seizures	_____	<input type="checkbox"/>
<input type="checkbox"/> Other	_____	<input type="checkbox"/>	<input type="checkbox"/> Other	_____	<input type="checkbox"/>

## Social History: Please respond to each category

	<u>Current/former use</u>		<u>Amount used</u>				<u>Type</u>			<u>Frequency used</u>			<u>Age stopped</u>
<b>Smoking</b>	Yes	No	.25	.50	1	≥1.5	Cig	Pack	Cigar	Day	Week	Year	_____
<b>Alcohol</b>	Yes	No	1	2	3	≥4	Wine	Liquor	Beer	Week	Month	Year	_____
<b>Caffeine</b>	Yes	No	1	2	3	≥4	Coffee	Tea	Soda				_____

## Blood Sugar: Please complete if you are diabetic, pre-diabetic, or have your blood sugar checked regularly as a precautionary measure

Last blood sugar reading: \_\_\_\_\_ Date and estimated time: \_\_\_\_\_  
 Last known A-1C: \_\_\_\_\_ Date blood was taken: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Tech Initials:** \_\_\_\_\_