

Are you sensitive in bright sunlight? Yes/No

What hobbies or recreational sports do you enjoy? _____

Medical Information

What is your general health? _____

Do you have problems with any of these systems? (Please circle yes or no.)

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High Blood Pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain _____

Diabetes Yes/No Type _____ Date of Diagnosis _____

Allergies to Medication Yes/No Which? _____ Reactions? _____

Other health problems _____

Current medication(s) _____

Name of primary care physician _____

Date of last visit _____

Family History

High blood pressure Yes/No Relation _____

Macular degeneration Yes/No Relation _____

Diabetes Yes/No Relation _____

Retinal detachment Yes/No Relation _____

Glaucoma Yes/No Relation _____

Cataracts Yes/No Relation _____