PRIMARY CARE PHYSICIAN:  CURRENT MEDICATIONS INCLUDING SUPPLEMENTS: (continue listing on pack of this sheet if more room is needed)  Name of Medicine  PATIENT MEDICAL HISTORY:  Date  PATIENT MEDICAL HISTORY:  Date  SURGICAL HISTORY:  DATE  TYPE OF SURGERY  DATE  TYPE OF SURGERY  DATE  TYPE OF SURGERY  DO you live alone?  DO you shoek?  NO  YES  DO you shoek?  NO  YES  TAMILY HISTORY:  Has a blood related family member ever had any of the following?  (What relation)  What relation)  Relations  NO  YES  Slaucoma  NO  YES  NO  YES  Slaucoma  NO  YES  NO  YE	CHART#NAME:PRIMARY CARE PHYSICIAN:			DATE:	
CURRENT MEDICATIONS INCLUDING SUPPLEMENTS: (continue listing on back of this sheet if more recent is needed)  Name of Medicine  PATIENT MEDICAL HISTORY:  Date  Date  Date  SURGICAL HISTORY:  DATE  TYPE OF SURGERY  DATE  TYPE OF SURGERY  DO you live alone?  NO YES  DO you sonsume alcoholic beverages?  NO YES  TAMILY HISTORY:  Has a blood related family member ever had any of the following?  (What relation)  Siaucoma  NO YES  Siaucoma  NO YES  Siaucoma  NO YES  Siaucoma  NO YES  Acculated begeneration  NO YES  Acculated begeneration  NO YES  Acculated begeneration  NO YES  Siaucoma  NO YES  NO YES  Siaucoma  NO YES  Siaucoma  NO YES  Siaucoma  NO YES  NO YES  Siaucoma  NO YES  NO YES  Siaucoma  NO YES  NO YES					
PATIENT MEDICAL HISTORY:  Date  Date  SURGICAL HISTORY:  DATE  TYPE OF SURGERY  DATE  TYPE OF SURGERY  DO you live alone?  NO YES  DO you sonsume alcoholic beverages?  NO YES  DO you sonsume alcoholic beverages?  NO YES  ALLERGIC TO: (List medication allergies) and any other known allergies)  SURGICAL HISTORY:  TYPE OF SURGERY  DATE  TYPE OF SURGERY  TYPE OF SURGERY  TYPE OF SURGERY  OF YES  DO you live alone?  NO YES  ACUATO POWER  FAMILY HISTORY: Has a blood related family member ever had any of the following?  (What relation)  SIBLUCOMB  NO YES  ACUATO POWER  ACUATO POWER  ACUATO POWER  ACUATO POWER  ACUATO POWER  SIBLUCOMB  NO YES  SIBLUCOMB  NO YES  SIBLUCOMB  NO YES  SIBLUC					
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SURGICAL HISTORY:  DATE TYPE OF SURGERY DATE TYPE OF SURGERY  SOCIAL HISTORY:  Do you live alone? NO YES  Do you consume alcoholic beverages? NO YES  Do you consume alcoholic beverages? NO YES  FAMILY HISTORY: Has a blood related family member ever had any of the following?  (What relation)  Glaucoma NO YES  Dataract NO YES  Macular Degeneration NO YES  Macular Degeneration NO YES  Macular Degeneration NO YES  Sorssed Eye or Lazy Eye NO YES  Blindness NO YES	PATIENT MEDICAL HISTO			RY:	
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Occupation?  FAMILY HISTORY: Has a blood related family member ever had any of the following?  (What relation) Occupation	Do you live alone?				
Po you consume alcoholic beverages? NO YES  PAMILY HISTORY: Has a blood related family member ever had any of the following?  (What relation)  Glaucoma  NO YES  Cataract  NO YES  Macular Degeneration  Retinal Detachment  NO YES  Crossed Eye or Lazy Eye  NO YES  Slindness  NO YES  Chyroid Disease  NO YES  Clabetes  NO YES  Charact  NO YES  Chyroid Disease  NO		NO	123		+
FAMILY HISTORY: Has a blood related family member ever had any of the following?  (What relation)  Glaucoma  NO YES  Macular Degeneration Retinal Detachment NO YES  Crossed Eye or Lazy Eye NO YES  Slindness NO YES  Chyroid Disease NO YES  Diabetes NO YES  Heart Disease NO YES  Stroke NO YES		alcoholic heverages?	NO VES		
FAMILY HISTORY: Has a blood related family member ever had any of the following?  (What relation)			NO ILS		
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Glaucoma         NO         YES           Cataract         NO         YES           Macular Degeneration         NO         YES           Retinal Detachment         NO         YES           Crossed Eye or Lazy Eye         NO         YES           Blindness         NO         YES           Thyroid Disease         NO         YES           Diabetes         NO         YES           Heart Disease         NO         YES           Stroke         NO         YES           High Blood Pressure         NO         YES		FAMILY HISTORY	: Has a blood rel	lated family member eve	r had any of the following?
Cataract         NO         YES           Macular Degeneration         NO         YES           Retinal Detachment         NO         YES           Crossed Eye or Lazy Eye         NO         YES           Blindness         NO         YES           Thyroid Disease         NO         YES           Diabetes         NO         YES           Heart Disease         NO         YES           Stroke         NO         YES           High Blood Pressure         NO         YES					(What relation)
Macular Degeneration         NO         YES           Retinal Detachment         NO         YES           Crossed Eye or Lazy Eye         NO         YES           Blindness         NO         YES           Thyroid Disease         NO         YES           Diabetes         NO         YES           Heart Disease         NO         YES           Biroke         NO         YES           High Blood Pressure         NO         YES					
Retinal Detachment         NO YES           Crossed Eye or Lazy Eye         NO YES           Blindness         NO YES           Thyroid Disease         NO YES           Diabetes         NO YES           Heart Disease         NO YES           Stroke         NO YES           High Blood Pressure         NO YES					
Crossed Eye or Lazy Eye         NO YES           Blindness         NO YES           Thyroid Disease         NO YES           Diabetes         NO YES           Heart Disease         NO YES           Stroke         NO YES           High Blood Pressure         NO YES					
NO YES					
Interpretation         NO         YES           Diabetes         NO         YES           Heart Disease         NO         YES           Stroke         NO         YES           High Blood Pressure         NO         YES					
Diabetes         NO         YES           Heart Disease         NO         YES           Stroke         NO         YES           High Blood Pressure         NO         YES					
Heart Disease					
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