Medical History: Please check affected person (if any) next to the appropriate diagnosis.

	Self (Patient)	Father	Mother	Brother	Sister	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
Cataracts									
Cataract Surgery									
Glaucoma									
Macular Degeneration									
Retinal Detachment									
Arthritis									
Rheumatoid Arthritis									
Asthma									
Cancer (list type)									
Cancer (list type)									
Cancer (list type)									
Cancer (list type)									
Elevated Cholesterol									
Diabetes									
Heart Disease									
Hypertension									
Lupus Erythematosus									
Stroke									
Hypothyroidism									
Hyperthyroidism									
Other (please list)									
Other (please list)									
Other (please list)									
Other (please list)									

Please list current Medications (prescription or OTC) and/or Vitamins:

_____

_____

Allergies:

_____

_____