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**Denton R. Roberts, M.D.**

HISTORY FORM – CONFIDENTIAL

Name: \_\_\_\_\_

What problem(s) brought you to clinic today? \_\_\_\_\_

Allergies (Medicine): \_\_\_\_\_

Current Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Past Ocular History: \_\_\_\_\_

\_\_\_\_\_

Past Medical History: \_\_\_\_\_

\_\_\_\_\_

Past Surgical History: \_\_\_\_\_

\_\_\_\_\_

Family History:

Ocular Condition:	Relationship:	Medical Condition:	Relationship:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you smoke? (Circle one) Y N Formerly How much? \_\_\_\_\_ How long? \_\_\_\_\_

Do you use alcohol? Y N How much? \_\_\_\_\_ How often? \_\_\_\_\_

Do you drink caffeine? Y N How much per day? \_\_\_\_\_

Do you use recreational drugs? (Circle one) Y N Formerly