Medical History

Name:_____ Today's Date:_____/_____/_____

Address:_____ Phone:_____

_____ Occupation:_____

Birth Date:_____/_____/_____ If New Patient, Last Eye Exam: _____/_____/_____

Name of Medical Doctor:_____ Last Medical Exam:_____/_____/_____

Hobbies:_____ Daily Hours of Computer Use:_____ Referred By:_____

Medical History

Do you have any allergies or allergies to medications? ❑ no ❑ yes If yes, explain:_____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

_____

List all major injuries, surgeries and /or hospitalizations you have had:_____

_____

List any of the following that <u>you</u> have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Are you pregnant and /or nursing? ❑ no ❑ yes

Do you wear glasses? ❑ no ❑ yes If yes, how old is your present pair of lenses?_____

Do you wear contact lenses? ❑ no ❑ yes If yes, how old is your present pair of lenses?_____

Type of contact lenses: ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other Are they comfortable? ❑ yes ❑ no

How often do you replace your contact lenses? _____How long have you worn contact lenses?_____Type of solutions:_____

Do you need a copy of your prescription for glasses? ❑ no ❑ yes Contact lenses? ❑ no ❑ yes

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	❑	❑	❑	
Cataract	❑	❑	❑	
Crossed Eyes	❑	❑	❑	
Glaucoma	❑	❑	❑	
Macular Degeneration	❑	❑	❑	
Retinal Detachment/Disease	❑	❑	❑	
Arthritis	❑	❑	❑	
Cancer	❑	❑	❑	
Diabetes	❑	❑	❑	
Heart Disease	❑	❑	❑	
High Blood Pressure	❑	❑	❑	
Kidney Disease	❑	❑	❑	
Lupus	❑	❑	❑	
Thyroid Disease	❑	❑	❑	
Other_____	❑	❑	❑	

Please turn this form over and complete side two

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

☐ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? ☐ no ☐ yes If yes, do you have visual difficulty when driving? ☐ no ☐ yes If yes, please describe:

Do you use tobacco products? ☐ no ☐ yes If yes, type/amount/how long: _____

Do you drink alcohol? ☐ no ☐ yes If yes, type/amount/how long: _____

Do you use illegal drugs? ☐ no ☐ yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ None

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	☐	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
ENDOCRINE			
Thyroid/Other Glands	☐	☐	☐

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR / CARDIOVASCULAR			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals/Kidney/Bladder	☐	☐	☐
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC / HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain:

_____

_____

_____

_____

_____

_____ _____

Doctor's Signature Date