MEDICAL HISTORY

Name_____ Date____/____/____

Address_____ Phone_____

City_____ State_____ Zip_____ Work Phone_____

Guardian (if applicable)_____ Occupation_____

Birthdate ____/____/____ Email_____ Last Eye Exam ____/____/____

Do you have vision insurance? ❒ No ❒ Yes If yes, insurance carrier_____

Do you have health insurance? ❒ No ❒ Yes If yes, insurance carrier_____

Do you have medicare? ❒ No ❒ Yes

Medical History

Do you have any allergies to medication? ❒ No ❒ Yes If yes, explain_____

List medications you take (including oral contaceptives, 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 you have had - crossed eyes, lazy eye, drooping eyelid, glaucoma, cataracts, retinal disease, 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? ❒ No ❒ Yes

Eyes - Conditions

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

Disease/Condition	No	Yes	
Loss of Vision	❒	❒	_____
Blurred Vision	❒	❒	_____
Distorted Vision/Halos	❒	❒	_____
Loss of Side Vision	❒	❒	_____
Double Vision	❒	❒	_____
Dryness	❒	❒	_____
Mucous Discharge	❒	❒	_____
Redness	❒	❒	_____
Sandy or Gritty Feeling	❒	❒	_____
Itching	❒	❒	_____

Eyes - Conditions (continued)

	No	Yes	
Burning	❒	❒	
Foreign Body Sensation	❒	❒	
Excess Tearing/Watering	❒	❒	
Glare Light Sensativity	❒	❒	
Eye Pain or Soreness	❒	❒	
Chronic Infection of Eye or Lid	❒	❒	
Sties or Chalazion	❒	❒	
Flashes or Floaters in Vision	❒	❒	
Tired Eyes	❒	❒	

Patient Family History

			Self	Relationship (Father, Mother, etc.)
Blindness	❒	❒		
Cataract	❒	❒		
Crossed Eyes	❒	❒		
Glaucoma	❒	❒		
Macular Degeneration	❒	❒		
Retinal Detachment/Disease	❒	❒		
Arthritis	❒	❒		
Cancer	❒	❒		
Diabetes	❒	❒		
Heart Disease	❒	❒		
High Blood Pressure	❒	❒		
Kidney Disease	❒	❒		
Lupus	❒	❒		
Throid Disease	❒	❒		
Other	❒	❒		

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

❒ Yes, I prefer to discuss my Social History information directly with the doctor.

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

Review of Systems

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

	No	Yes
Constitutional		
Fever, Weight Loss/Gain	☐	☐
Integumentary		
Skin	☐	☐
Neurological		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Endocrine		
Thyroid/Other Glands	☐	☐
Ear, Nose, Mouth, Throat		
Allergies/Hay Fever	☐	☐
Sinus Congestion	☐	☐
Runny Nose	☐	☐
Post-Nasal Drip	☐	☐
Chronic Cough	☐	☐
Dry Throat/Mouth	☐	☐
Respiratory		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐

	No	Yes
Vascular/Cardiovascular		
Diabetes	☐	☐
Heart Pain	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
Gastrointestinal		
Chronic Diarrhea	☐	☐
Chronic 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 and list medications:

Doctor's Signature_____ Date _____/_____/_____