## **MEDICAL HISTORY**

Name					Date/	/
Address					Phone	
City					Work Phone	
Guardian (if applicable)					Occupation	
Birthdate//						
Do you have vision insurance?						
Do you have health insurance?						
	□No□`		TEYE	73/2		
Medical History  Do you have any allergies to me	edication?	□No	□ Yes If ye	es, explain		
List medications you take (incl	uding oral	contace	ptives, aspirin, o	ver-the-counte	r medications and home rem	edies)
List all major injuries, surgerie	s and/or h	ospitaliz	ations you have	had		
List any of the following that y eye infections, or eye injury						retinal disease
Are you pregnant and/or nursir	ıg? □No	☐ Yes				
Do you wear glasses?		☐ Yes			sent pair of lenses?	
Do you wear contact lenses?		☐ Yes			sent pair of lenses?	
Type of contact lenses: ☐ Rig			Extended Wear	☐ Other	Are they comfortable?	□No □Ye
Eyes - Conditions						
Please note any family history	(parents,	grandpar	ents, siblings, cl	nildren; living	or deceased) for the followir	ng conditions:
Disease/Condition	No	Yes				
Loss of Vision						
Blurred Vision			, S			
Distorted Vision/Halos		0				
Loss of Side Vision		0				
Double Vision					**	
Dryness						
Mucous Discharge						
Redness						
Sandy or Gritty Feeling						
Itching						

No Ves Burning	Eyes - Conditions (continue	d)	é		
Barning		No	Yes		
Excess Tearing/Watering Glare Light Sensativity	Burning				
Glare Light Sensativity Eye Pain or Soreness Chronic Infection of Eye or Lid Sties or Chalazion Flashes or Floaters in Vision	Foreign Body Sensation			89 Y	071
Chronic Infection of Eye or Lid	Excess Tearing/Watering			10000	IRRODATE TO THE TAXABLE PROPERTY.
Chronic Infection of Eye or Lid	Glare Light Sensativity				the season more angions conve
Sties or Chalazion	Eye Pain or Soreness	wee 🗖 i bo		in y	Gintental
Flashes or Floaters in Vision	Chronic Infection of Eye or L	id 🗖		2/	CI SIZ
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 Cotter Cott	Sties or Chalazion				langole
Relationship (Father, Mother, etc.)  Blindness	Flashes or Floaters in Vision		í 🗇		eadaches
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	o you drink alcohol?	No 🗆			
ave you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis	o you use illegal drugs?	JNo 🗆	Yes	If yes, type/amount/how long	
	ave 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		No	Yes
Constitutional			Vascular/Cardiovascular		
Fever, Weight Loss/Gain			Diabetes		
ntegumentary			Heart Pain		
Skin			High Blood Pressure		
Journalogical			Vascular Disease		ni 🗆 1016
leurological Headaches		<i>i</i>	Gastrointestinal		
Migraines			Chronic Diarrhea	FloDom	no 🗆 riae
Seizures			Chronic Constipation		
	J	D	Genitourinary		
Endocrine			Genitals/Kidney/Bladder		
Thyroid/Other Glands			and the construction of th		
Car, Nose, Mouth, Throat			Bones/Joints/Muscles Rheumatoid Arthritis	4	Kuntah
Allergies/Hay Fever	0	0	and the company of th		
Sinus Congestion					RESIDOUS
Runny Nose			Joint Pain	agenemit	
Post-Nasal Drip			Lymphatic/Hematologic		
Chronic Cough			Anemia		
Dry Throat/Mouth			Bleeding Problems		
	marina 🚨 marina		Allergic/Immunologic		
Respiratory			Psychiatric		
Asthma	0		1 sy chiatric	U oca	cart buse
Chronic Bronchitis					
Emphysema					
			ndition not listed, please explain and list medicatio		her
ndirectly with the doctor if how prefer	to hag and :	эксмій укс	his information is kept strictly confidential. However, you o	i - 710	eiH Ini
line doctor.	abi e glace	alb aoim	Yes, I prefer to discuss my Social History inform		
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Doctor's Signature			Date/_		