Mallinger
FAMILY
EYE CARE

Health History

Reason for today's exam _____

_____

Date of last exam _____ Name of eye doctor _____

Please list all medications you are currently taking _____

_____

Allergies to Medications: _____

If female, are you pregnant or nursing? _____

Past surgeries: _____

Have **YOU** ever had any of the following conditions involving your eyes?

□Glaucoma □Cataracts □ Dry Eyes □Floaters □Refractive Surgery □Allergies

□Color Deficiency □Strabismus/ Lazy Eye □Retinal Disease/Detachment

□Macular Degeneration □Eye Surgery_____ □Other _____

Does anyone in your **FAMILY** have of any of the following? IF YES, WHOM?

□Glaucoma _____ □Cataracts _____ □ Color Deficiency_____

□Blindness _____ □Strabismus/Lazy Eye_____ □ Macular Degeneration _____

□Diabetes _____ □ High Blood Pressure _____

□Retinal Disease/Detachment_____ □ Other _____

Do you currently wear glasses? □Yes □No If yes, how old are they? _____

Have you ever worn Contact Lenses? □Yes □No Are you interested in contacts? □Yes □No

Brand of Contacts_____ Do you sleep in your contacts? □Yes, ____days per month □No

Do you work at a computer or video display terminal? □Yes, _____ hours per day □No

Do you have visual difficulty when driving? □ Yes □No If yes, explain: _____
Do you use tobacco products? □Yes □No If yes, type/amount/how long: _____
Do you use illegal drugs? □Yes □No If yes, type/amount/how long: _____
Do you drink alcohol? □Yes □No If yes, type/amount/how long: _____
Have you ever been exposed to or infected with: □Gonorrhea □Hepatitis □HIV □ Syphilis

Please indicate any problem you have or have had in any of the following areas:

SYSTEM	*YES*	*NO*
CONSTITUTIONAL		
Fever, Weight Loss/Gain	□	□
SKIN CONDITIONS	□	□
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	□	□
Styes or Chalazia	□	□
Flashes/Floaters	□	□
Tired Eyes	□	□
Glaucoma	□	□
GENITOURINARY		
Kidney/Bladder/Genitalia	□	□

SYSTEM	*YES*	*NO*
EARS, NOSE, MOUTH, THROAT		
Allergies/Hay Fever	□	□
Sinus Congestion	□	□
Runny Nose	□	□
Chronic Cough	□	□
Dry Throat/Mouth	□	□
RESPIRATORY		
Asthma	□	□
Chronic Bronchitis	□	□
Emphysema	□	□
VASCULAR/CARDIOVASCULAR		
Diabetes	□	□
Heart Pain	□	□
High Blood Pressure	□	□
Vascular Disease	□	□
GASTROINTESTINAL		
Stomach/Intestines	□	□
BONES/JOINTS/MUSCLES		
Rheumatoid Arthritis	□	□
Muscle Pain	□	□
Joint Pain	□	□
LYMPHATIC/HEMATOLOGIC		
Anemia	□	□
Bleeding Problems	□	□
HIGH CHOLESTEROL	□	□
ENDOCRINE		
Thyroid	□	□
PSYCHIATRIC		
Depression/Anxiety	□	□

If "yes" to any of the above or if a condition is not listed, please explain below:

_____

_____

_____

_____