MEDICAL HISTORY

Name _____ Date of Birth_____

Date of Last **Eye** Exam _____ Doctor: _____

Date of Last **Medical** Exam _____ Doctor: _____

Medical History

Do you have any allergies to medication? □ No □ Yes If yes, explain _____

_____

List any medications you take **OR** provide a list for photocopying (include oral contraceptives, aspirin, over-the-counter medications, etc.) _____

_____

_____

_____

_____

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

_____

_____

List any **EYE** injuries or surgeries:_____

_____

List any of the following **YOU** have had (crossed eyes, lazy eye, drooping eyelid, glaucoma, cataracts, retinal disease, or eye infections) _____

_____

_____

Do you wear **glasses**? □ No □ Yes

Do you wear **contact lenses**? □ No □ Yes

Family History

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

Disease/Condition	No	Yes	Relationship To You
Blindness	□	□	_____
Crossed eyes	□	□	_____
Glaucoma	□	□	_____
Macular Degeneration	□	□	_____
Retinal Detachment/Disease	□	□	_____
Diabetes	□	□	_____
Other	□	□	_____

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Social History

Do you drive? □ No □ Yes If yes, do you have visual difficulty when driving? □ No □ Yes

Do you use tobacco products? □ No □ Yes If yes, type/amount? _____

Do you drink alcohol? □ No □ Yes If yes, type/amount? _____

Review of Systems

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

	No	Yes
Constitutional		
Unexpected Weight Loss/Gain	□	□
Fever	□	□
Integumentary(Skin)		
Metal allergy	□	□
Rosacea	□	□
Neurological		
Seizures	□	□
Alzheimer's	□	□
Headaches/Migraines	□	□
Eyes		
Blurred vision	□	□
Distorted Vision/Halos	□	□
Glare/Light Sensitivity	□	□
Double Vision	□	□
Loss of Vision	□	□
Floaters	□	□
Flashes of light	□	□
Dryness	□	□
Redness	□	□
Burning	□	□
Itching	□	□
Watering/Discharge	□	□
Mucous Discharge	□	□
Foreign Body Sensation	□	□
Stye or Chalazion	□	□
Eye Pain or Soreness	□	□
Eye Fatigue	□	□

	No	Yes
Endocrine		
Diabetes Mellitus	□	□
Thyroid	□	□
Ears, Nose, Throat		
Allergies	□	□
Sinus Infections	□	□
Dry Throat/Mouth	□	□
Respiratory		
Asthma	□	□
Lung Disease	□	□
COPD	□	□
Vascular/Cardiovascular		
High Blood Pressure	□	□
High Cholesterol	□	□
Heart Disease	□	□
Stroke	□	□
Gastrointestinal		
Acid Reflux	□	□
Intestinal Problems	□	□
Liver/Spleen	□	□
Genitourinary		
Genitals/Kidney/Bladder	□	□
Bones/Joints/Muscles		
Rheumatoid Arthritis	□	□
Muscle/Joint Pain	□	□
Lymphatic/Hematologic		
Anemia/Blood Disorder	□	□
Cancer		
Type _____		
Year of diagnosis _____		

If you have a condition not listed, please explain:

_____

_____

_____

Patient's Signature _____ **Date:** _____

Doctor's Signature _____ **Date:** _____

Date Reviewed: _____ _____ _____ _____ _____ _____ _____ _____

Date Initials Date Initials Date Initials Date Initials