Medical History

Today's Date_____

Patient Name_____ DOB _____
Male/Female

Guardian/ Parent Name_____

Address_____ City_____ State___ Zip Code_____

Best Phone Number_____ Email_____

Social Security Number_____ Insured person _____DOB_____

Medical Insurance_____ Member Number_____

Vision Insurance_____ Member Number/Social Security_____

Are you having any of these ocular symptoms:

Loss of vision _____	Itching_____	Eye pain_____
Blurred Vision_____	Burning_____	Eye Strain____
Double Vison_____	Foreign body sensation____	Flashes of light_____
Dryness_____	Tearing/Watering_____	Floaters_____
Mucous_____	Glare_____	Gritty feeling_____
Redness_____	Light Sensitivity____	Tired eye_____

Difficulty focusing between near and distance_____

Have you been diagnosed with:

Cataracts_____ Glaucoma_____ Macular Degeneration_____ Diabetes/ Diabetic Retinopathy_____

Do you wear glasses? Y/N Need improvement? Y/N

Do you wear contacts? Y/N Brand? _____ Need improvement? Y/N

Do you use computers for long periods of time? Y/N How many hours per day? _____

Basic Health History: (please circle)

Constitutional: Cancer, Developmental Disabilities, Fatigue Syndrome, Other_____

ENT: Hearing Loss, Sinusitis, Dry Mouth, Laryngitis, Other_____

Neuro: Multiple Sclerosis, Epilepsy, Cerebral Palsy, Tumor, Stroke, Migraines, Autism, Other_____

Psych: Depression, Attention Deficit Disorder, Anxiety Disorder, Bipolar Disorder, Other_____

Cardiovasc: Hypertension, Stroke, Heart Disease, Vascular Disease, Congestive Heart Failure, Other_____

Resp: Asthma, Bronchitis, Emphysema, COPD, Sleep Apnea, Other_____

GI: Crohn's, Colitis, Ulcer, Acid Reflux, Celiac Disease, Other_____

GU: Kidney Disease, Pregnant, STD, Prostate Disease, Other_____

Musc/Skel: Arthritis, Fibromyalgia, Muscular Dystrophy, Osteoporosis, Other_____

Integ: Eczema, Rosacea, Psoriasis, Cold Sores, Shingles, Other_____

Endo: Diabetes Type 1, Diabetes Type 2, Thyroid Dysfunction, Hormonal Dysfunction, Other_____

Hem/Lymph: Anemia, Ulcer, Cholesterol, Other_____

Allergy/Imm: Environmental Allergies, Drug Allergies, Rheumatoid Arthritis, Sjogren's, Other_____

Current Medications_____
_____
_____
_____

Drug Allergies_____
_____

Other Allergies_____

Do you Smoke Y/N or Drink Y/N?

Family History:

Cancer Y/N Who? _____

Diabetes Y/N Who? _____

Thyroid Y/N Who? _____

Hypertension Y/N Who? _____

Cataract Y/N Who? _____

Glaucoma Y/N Who? _____

Macular Degeneration Y/N Who? _____