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