MEDICAL HISTORY

Name _____ Date _____/_____/_____
Address _____
City _____ State _____ Zip _____
Birth date _____/_____/_____ Last Eye Exam _____/_____/_____
E-Mail: _____Cell Phone: _____
Occupation: _____ Employer: _____
Do you have vision insurance? ❒Yes ❒No If yes, insurance carrier _____
Do you have health insurance? ❒Yes ❒No If yes, insurance carrier _____
Name of family doctor: _____ Phone: _____

Medical History

Height: _____ Weight: _____

Do you have any allergies to medication? ❒ Yes ❒ No If yes, explain _____
_____
List medications you take (including oral contraceptives, aspirin and over-the-counter medications):
_____
_____
_____

List all major injuries, surgeries, and/or hospitalizations you have had:
_____
List any of the following that you have had – crossed eyes, lazy eye, drooping eyelid, glaucoma, cataracts, retinal disease, eye infections, or eye injury: _____
Are you pregnant and/or nursing? ❒ Yes ❒ No
Do you wear glasses? ❒ Yes ❒ No If yes, how old is your present pair of lenses? _____
Do you wear contact lenses? ❒ Yes ❒ No If yes, how old is your present pair of lenses? _____
Type of contact lenses: ❒ Rigid ❒ Soft ❒ Extended Wear ❒ Other Are they comfortable? ❒ Yes ❒ No

Review of Systems

	Yes	No
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	❒	❒

	Yes	No
Glare/Light Sensitivity	❒	❒
Eye Pain or Soreness	❒	❒
Chronic Eye Infection	❒	❒
Sties or Chalazion	❒	❒
Flashes/Floaters in Vision	❒	❒
Tired Eyes	❒	❒
Cardiovascular/Vascular		
High Cholesterol	❒	❒
Heart Pain	❒	❒
High Blood Pressure	❒	❒
Vascular Disease	❒	❒
Endocrine		
Diabetes	❒	❒
Thyroid/Other Glands	❒	❒

	Yes	No
Ears, Nose, Mouth, Throat		
Allergies/Hay Fever	❒	❒
Sinus Congestion	❒	❒
Dry Throat/Mouth	❒	❒
Constitutional		
Fever, Weight Loss/Gain	❒	❒
Integumentary (Skin)	❒	❒
Neurological		
Headaches or Migraines	❒	❒
Seizures	❒	❒
Respiratory		
Asthma	❒	❒
Chronic Bronchitis	❒	❒
Emphysema	❒	❒

	Yes	No
Gastrointestinal		
Chronic Diarrhea	❒	❒
Chronic Constipation	❒	❒
Genitourinary		
Kidney/Bladder/Genitals	❒	❒
Bones/Joints/Muscles		
Rheumatoid Arthritis	❒	❒
Muscle Pain	❒	❒
Joint Pain	❒	❒
Lymphatic/Hematologic		
Anemia	❒	❒
Bleeding Problems	❒	❒
Allergic/Immunologic	❒	❒
Psychiatric	❒	❒

If you answered yes to any of the above, or have a condition not listed, please explain and list medications:

_____

_____

_____

_____

Family History

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

Disease/Condition	Yes	No	Relationship
Blindness	❒	❒	
Cataract	❒	❒	
Crossed Eyes	❒	❒	
Glaucoma	❒	❒	
Macular Degeneration	❒	❒	
Retinal Detachment	❒	❒	
Arthritis	❒	❒	

	Yes	No	Relationship
Cancer	❒	❒	
Diabetes	❒	❒	
Heart Disease	❒	❒	
High Blood Pressure	❒	❒	
Kidney Disease	❒	❒	
Thyroid Disease	❒	❒	
Other	❒	❒	

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❒ Yes, I prefer to discuss my Social History information directly with the doctor.

Do you use tobacco products? ❒ Yes ❒ No If yes, type/amount/how long_____

Do you drink alcohol? ❒ Yes ❒ No If yes, type/amount/how long _____

Do you use illegal drugs? ❒ Yes ❒ No If yes, type/amount/how long _____

Have you ever been exposed to or infected with: ❒ Gonorrhea ❒ Hepatitis ❒ HIV ❒ Syphilis

I HAVE RECEIVED AND UNDERSTAND THE HIPAA PRIVACY NOTICE.

Patient's Signature_____ Date _____/_____/_____