

Medical History

Name: _____ Today's Date: ____/____/____

Birth Date: ____/____/____ Sex (check one): ___M ___F Race (circle one): White/Hispanic/African American

Previous Eye Doctor: _____ Last Eye Exam: ____/____/____

Name of Medical Doctor: _____ Last Medical Exam: ____/____/____

Pharmacy Name: _____ City/State: _____

Medical History

Do you have any allergies to medications? Yes No If yes, explain: _____

List any medications or ocular you take (including oral contraceptives, aspirin, over the counter medications, vitamins, home remedies, and eye drops): _____

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

List any eye disease, infection or surgery: _____

Are you pregnant and/or nursing? Yes No

Do you wear? Glasses Sunglasses Contact Lenses

Where did you get your present pair of glasses/contact lenses: _____

Are you interested in a contact lens examination today? Yes No

Type of contact lenses: Soft Rigid Any issues with your contacts? Yes No

Do you use a computer? Yes No Hours per Day: _____

Are you exposed to sun? Yes No Hours per Day: _____

Hobbies/Interests: _____

Family History

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

DISEASE/CONDITION	Yes	No	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Social History: *This information is kept strictly confidential; however, you may discuss this portion with the doctor if you prefer.*

Do you drive? Yes No

Do you have difficulty with glare? Yes No

Do you use tobacco products? Yes No If yes, type / amount / how long: _____

Have you ever used tobacco products in your lifetime? Yes No If yes, how long ago did you quit? _____

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

Review of Systems

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

SYSTEM	Yes	No	?		Yes	No	?
CONSTITUTIONAL							
Fever, Weight Loss / Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
INTEGUMENTARY (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
NEUROLOGICAL							
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
EYES							
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Distorted Vision / Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Itching / Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Excess Tearing / Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Glare / Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Chronic Infection of Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Sties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Flashes of Light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
ENDOCRINE							
Thyroid / Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
				EARS, NOSE, MOUTH, THROAT			
				Allergies / Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Post – Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Dry Throat / Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				RESPIRATORY			
				Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				VASCULAR / CARDIOVASCULAR			
				Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				GASTROINTESTINAL			
				Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				GENITOURINARY			
				Genitals/ Kidneys / Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				BONES / JOINTS / MUSCLES			
				Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				LYMPHATIC / HEMATOLOGIC			
				Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				ALLERGIC/IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Other: _____			

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

Doctor's Signature

Date