

# MEDICAL HISTORY

Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Guardian (if applicable) \_\_\_\_\_ Email \_\_\_\_\_  
 Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Eye Exam \_\_\_\_/\_\_\_\_/\_\_\_\_ Occupation \_\_\_\_\_  
 Do you have vision insurance?  No  Yes If yes, insurance carrier \_\_\_\_\_  
 Do you have health insurance?  No  Yes If yes, insurance carrier \_\_\_\_\_  
 Do you have medicare?  No  Yes

## Medical History

List medications you take (including oral contraceptives, aspirin, over-the-counter medications, and home remedies)

\_\_\_\_\_

\_\_\_\_\_

Check any of the following that you have had:  age-related macular degeneration  inflammatory disorder  
 cataract  strabismus  kerataconus  amblyopia  glaucoma suspect  glaucoma  surgery  
 retinal degeneration/hole/detachment  patching  eye injury

Are you pregnant and/or nursing?  No  Yes  
 Do you wear glasses?  No  Yes If yes, how old is your present pair of lenses? \_\_\_\_\_  
 Do you wear contact lenses?  No  Yes If yes, what brand? \_\_\_\_\_  
 Type of contact lenses:  Rigid  Soft  Extended Wear  Other Are they comfortable?  No  Yes

## Family History

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

Disease/Condition	Yes	No	?	Relationship
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Strabismus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma Suspect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Severe Myopia	<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"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Severe Hyperopia	<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 directly with the doctor if you prefer.

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

Do you drive?  No  Yes If yes, do you have visual difficulty when driving?  No  Yes If yes, please describe: \_\_\_\_\_

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

Are you a  Former Smoker  Current Occasional Smoker  Current Everyday Smoker

Do you drink alcohol?  No  Yes If yes, type/amount/how long \_\_\_\_\_

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

Name \_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Review of Systems** Do you currently, or have you ever had, any problems in the following areas:

	Yes	No
<b>Eyes</b>		
Itching	<input type="checkbox"/>	<input type="checkbox"/>
Diplopia	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>
Mattering	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>
Photophobia	<input type="checkbox"/>	<input type="checkbox"/>
Red	<input type="checkbox"/>	<input type="checkbox"/>
Floaters	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Sharpness	<input type="checkbox"/>	<input type="checkbox"/>
Flashes	<input type="checkbox"/>	<input type="checkbox"/>
Tearing	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Constitutional</b>		
Developmental Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Ear, Nose, Mouth, Throat</b>		
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Laryngitis	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Neurological</b>		
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/CVA	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Psychiatric</b>		
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Vascular/Cardiovascular</b>		
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Respiratory</b>		
Cigarette Smoker	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
<b>Respiratory (continued)</b>		
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Gastrointestinal</b>		
Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Genitourinary</b>		
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
STD - Herpetic/Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Disease/Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant/Nursing	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Musculoskeletal</b>		
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Ankylosing Spondylitis	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Integumentary</b>		
Herpes Simplex/Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>
Herpes Zoster/Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Rosacea	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Endocrine</b>		
Diabetes Type II	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Hormonal Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Type I	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Hematologic/Lymphatic</b>		
Large Volume Blood Loss	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<b>Allergic/Immunologic</b>		
Environmental Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Drug Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Sjogrens Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

If you answered yes to any of the above, or have a condition not listed, please explain:  
\_\_\_\_\_  
\_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_