Eye Care Center Optometrist, PSC
Comprehensive Medical History

Name: _____ Today's Date: _____

Address: _____ City, State, Zip _____

Phone: _____ Work Phone: _____

Birthday: _____ Social Security Number: _____ Last Eye Exam: _____

Name Of Medical Doctor: _____ Last Eye Doctor: _____

Medical History

Do you have any allergies to medications? YES or NO ; If yes, explain:_____

List any medications you take including oral contraceptives, aspirin, over the counter medications and home remedies:
_____

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 eyelids, bulging eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Are you pregnant / nursing/ or planning pregnancy? YES or NO

Do you wear glasses? YES or NO If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? YES or NO If yes, how old is your present pair of lenses? _____

Type of contact lenses: Gas Perm, Soft, Extended Wear, Other _____

Are your lenses comfortable? YES or NO

Family History

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

DISEASE/CONDITION	**NO**	**YES**	**UNKOWN**	**RELATIONSHIP TO YOU**
Cataract	NO	YES	UNKOWN	_____
Blindness	NO	YES	UNKOWN	_____
Crossed Eyes	NO	YES	UNKOWN	_____
Glaucoma	NO	YES	UNKOWN	_____
Macular Degeneration	NO	YES	UNKOWN	_____
Retinal Detachment/Disease	NO	YES	UNKOWN	_____
Arthritis	NO	YES	UNKOWN	_____
Cancer	NO	YES	UNKOWN	_____
Diabetes	NO	YES	UNKOWN	_____
Heart Disease	NO	YES	UNKOWN	_____
High Blood Pressure	NO	YES	UNKOWN	_____
Kidney Disease	NO	YES	UNKOWN	_____
Lupus	NO	YES	UNKOWN	_____
Thyroid Disease	NO	YES	UNKOWN	_____
Other	NO	YES	UNKOWN	_____

Review of Systems

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

SYSTEM	NO	YES	SYSTEM	NO	YES
Fever; Weight gain/loss			Tired Eyes		
Skin Conditions/ Rash			Thyroid/other gland issues		
Headaches			Allergies/Hay Fever		
Migraines			Sinus Congestion		
Seizures			Runny Nose/Post nasal Drip		
Loss of Vision			Chronic Cough		
Blurred Vision			Dry Throat/Mouth		
Distorted Vision/Halos			Asthma		
Double Vision			Chronic Bronchitis		
Dryness of Eyes			Emphysema		
Loss of Side Vision (peripheral)			Diabetes		
Mucous Discharge of eyes			Heart Pain/Condition		
Redness of Eyes			High Blood Pressure		
Sandy or gritty feeling in eyes			Vascular Disease		
Itching or Burning in eyes			Diarrhea		
Foreign body sensation in eyes			Constipation		
Excess tearing/watering of eyes			Kidney or bladder disease		
Glare/Light Sensitivity			Rheumatoid Arthritis/ Muscle or Joint Pain		
Eye Pain or Soreness			Anemia		
Chronic infection eye/lid			Bleeding Problems		
Sties or Chalazion			Allergic/Immune Deficiencies		
Flashes/Floaters in Vision			Psychiatric		

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

_____

Social History: (the following information is kept strictly confidential. If you prefer only to discuss this information with the doctor directly circle the following "yes") YES

Do you drive? NO YES If yes, do you have vision problems when driving? _____ If yes, explain:

_____

Do you use tobacco? NO YES If yes, type/how much/how long:_____

Do you drink alcohol? NO YES If yes, type/how much/how long:_____

Do you use illegal drugs? NO YES If yes, type/how much/how long: _____

Have you ever been exposed to or infected with Gonorrhea, Hepatitis, HIV, or Syphilis. YES NO

Dr. Signature or Initials _____ Date _____