

Medical History

Name _____ Today's Date _____
Address _____ Date of Birth _____
_____ Occupation _____
Phone _____ Hobbies _____
Name of Primary Medical Doctor _____
Last Medical Exam _____ Last Eye Exam(with an eye doctor) _____

What is your reason for today's eye exam? Please mark all that apply.

blur at distance red eyes eye turn/crossed eyes
 blur at near glaucoma eye pain/discomfort
 computer strain flashes/spots itching
 double vision headache broken glasses
 vision loss tears/discharge contact lenses/color contact lenses

Have you had an eye injury? no yes If yes, explain: _____
Have you had eye surgery? no yes If yes, explain: _____
How old are your current glasses? _____
What brand contacts do you wear? (If unknown, state whether hard or soft) _____
How often do you replace your current contact lenses? daily 2 weeks monthly yearly

Medical History

Do you have, or have you ever been treated for:

diabetes (high sugar) arthritis/joint pain asthma/sleep apnea
 high blood pressure kidney/urinary depression/anxiety
 heart disease thyroid/glands sinus/allergy
 high cholesterol STD/HIV skin condition
 stomach problems cancer hearing loss
 stroke headache other _____

Do you take any medications? (including vitamins, birth control, Viagra, etc) no yes If yes, list: _____

Do you have any allergies to medication? no yes If yes, explain: _____
Are you pregnant? no yes Are you nursing? no yes
Do you smoke? no former smoker yes How much? 1/2 pack/day 1 pack/day 2-3 packs/day
Do you drink alcohol? no yes How much? social use only 1-2 drinks/day 3+ drinks/day
Do you have a history of recreational drug use? no yes

Please list your blood relatives (i.e. father, aunt, etc) who have the following medical problems:

_____ diabetes _____ high blood pressure _____ heart disease
_____ arthritis _____ sickle cell disease _____ retinal disease
_____ glaucoma _____ macular degeneration _____ crossed eyes
_____ blindness _____ other