EYE & MEDICAL HEALTH HISTORY FORM

Today's Date: _____ Patient Name _____ Age: _____

To help the doctor properly evaluate and treat your eye condition, please complete all information below.

Have you recently experienced any of the following symptoms with your eyes? (Please check all that apply) ☐ No Symptoms

☐ Blurry Vision	☐ Dry Eye	☐ Fluctuating Vision	☐ Light Sensitivity	☐ Redness
☐ Burning	☐ Eye Strain	☐ Headaches	☐ Loss of Vision	☐ Sandy or Gritty
☐ Crusting	☐ Flashes of Lights	☐ Itching	☐ Mucous Discharge	☐ Tearing or Watery
☐ Double Vision	☐ Floaters	☐ Injury	☐ Pain	☐ Other _____

Are you needing new glasses today? ☐ Yes ☐ No ☐ Only if necessary

Are you needing new contact lenses today? ☐ Yes ☐ No

CONTACT LENS HISTORY:

Have you worn contact lenses before? ☐ Yes ☐ No If yes, when did you last wear them? _____

How many hours do you typically wear your contacts? _____ Do you sleep in your contacts? ☐ Never ☐ Sometimes ☐ Always

What brand are your contacts? _____ Which cleaning solution do you use? _____

Please describe any problems you are having with your contacts: _____

ADDITIONAL VISION NEEDS:

Please list any sports, hobbies, or activities you do that may require special vision needs: _____

How many hours do you use a computer per day? _____

EYE HEALTH HISTORY:

Date of last eye exam: _____ Date of last eye dilation: _____ Previous Doctor: _____

Do you currently or have you previously had any of the following conditions with your eyes? ☐ NONE

☐ Crossed/Lazy Eye ☐ Blindness ☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Retinal Detachment ☐ Eye Surgery ☐ Injury ☐ Infection

FAMILY EYE HISTORY: Do any family members (parents, grandparents, brothers, sisters) have any of the following conditions? ☐ NONE

☐ Glaucoma ☐ Cataracts ☐ Macular Degeneration ☐ Retinal Detachment ☐ Crossed/Lazy Eye

MEDICAL HEALTH HISTORY:

Primary Care Physician: _____ Date of last visit: _____ How often do you see your doctor? _____

Please check the box if you have any of the following conditions:

GENERAL
- ☐ Cancer _____
- ☐ Developmental Disability
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain
- ☐ Weight Loss

EAR, NOSE, THROAT
- ☐ Ear Ache
- ☐ Hearing Loss
- ☐ Sinus Problems
- ☐ Dry Mouth
- ☐ Laryngitis

CARDIOVASCULAR
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Stroke
- ☐ Vascular Disease

RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ COPD

GENITOURINARY
- ☐ Kidney
- ☐ Bladder
- ☐ Prostate Disease
- ☐ STD _____

GASTROINTESTINAL
- ☐ Chron's Disease
- ☐ Colitis
- ☐ Hepatitis A / B / C
- ☐ Heartburn
- ☐ Ulcer

MUSCULOSKELATAL
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Head/Neck Injury

INTEGUMENTARY
- ☐ Eczema
- ☐ Growths
- ☐ Psoriasis
- ☐ Rash
- ☐ Rosacea

NEUROLOGICAL
- ☐ Cerebral Palsy
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Paralysis
- ☐ Seizures
- ☐ Tumor

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Mental Illness

ENDOCRINE
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Hyperthyroid
- ☐ Hypothyroid

HEMATOLOGIC
- ☐ Anemia
- ☐ High Cholesterol
- ☐ Excessive Bleeding

ALLERGIC/IMMUNOLOGIC
- ☐ Environmental Allergies
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ HIV

OTHER:
_____

FAMILY MEDICAL HISTORY: Do any family members have any of the following conditions? ☐ NONE

☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Thyroid ☐ Other _____

List any Injuries, Surgeries, or Hospitalizations you have had: _____

List all **MEDICATIONS** you are currently taking: _____

_____

_____

List all **VITAMINS** or **SUPPLEMENTS** you are taking: _____

List all over-the-counter **EYE DROPS** you are currently using: _____

List any **ALLERGIES to MEDICATIONS:** _____

FEMALES: Are you currently pregnant or nursing? ☐ Yes ☐ No

SOCIAL HISTORY:

Do you smoke? ☐ Never a Smoker ☐ Former Smoker ☐ Occasional Smoker ☐ Every day Smoker

Do you drink alcohol? ☐ Never ☐ Socially ☐ Daily

Do you use illegal drugs? ☐ No ☐ Yes ☐ Previous History of Abuse

VITALS: Height: _____ feet _____ inches Weight: _____ lbs.

Patient or Guarantor Signature: _____ **Date:** _____