Medical History Name: _____ Date: _____ DOB: _____

Family History

Ocular Conditions	WHO?	Systemic Conditions	WHO?
Amblyopia		Arthritis	
Blindness		Cancer	
Cataracts		Type 1 Diabetes	
Corneal Dystrophy		Type 2 Diabetes	
Crossed Eyes		Heart Disease	
Glaucoma		High Blood Pressure	
Macular Degeneration		Kidney Disease	
Retinal Disease		Thyroid Disease	
Retinal Detachment		Vascular Disease	

Patient History

EYES	Y	N
Blindness	☐	☐
Blurred Vision	☐	☐
Blepharitis	☐	☐
Cataracts	☐	☐
Chronic Eye Infection	☐	☐
Corneal Dystrophy	☐	☐
Crossed Eyes	☐	☐
Double Vision	☐	☐
Diabetic Retinopathy	☐	☐
Distorted Vision	☐	☐
Dry Eyes	☐	☐
Flashes	☐	☐
Floaters	☐	☐
Glaucoma	☐	☐
Halos	☐	☐
Itching	☐	☐
Light Sensitivity	☐	☐
Loss of Vision	☐	☐
Macular Degeneration	☐	☐
Red Eyes	☐	☐
Retinal Detachment	☐	☐
Tearing	☐	☐
Vision Therapy	☐	☐

EARS, NOSE, MOUTH, THOAT		
Allergies	☐	☐
Chronic Cough	☐	☐
Chronic Ear Infection	☐	☐
Dry Throat/ Mouth	☐	☐
Hearing Aids	☐	☐
Post-Nasal Drip	☐	☐
Runny Nose	☐	☐
Sinus Congestion	☐	☐

MUSCULOSKELETAL		
Arthritis	☐	☐
Joint Pain	☐	☐
Muscle Pain	☐	☐
Osteoporosis	☐	☐
Rheumatoid	☐	☐

CONSTITUTIONAL	Y	N
Fever	☐	☐
Malaise	☐	☐
Weight Gain	☐	☐
Weight Loss	☐	☐
IMMUNOLOGIC		
Hay Fever	☐	☐
HIV	☐	☐
Chemotherapy - Current	☐	☐
LYMPHATIC/HEMATOLOGIC		
Anemia	☐	☐
Bleeding Problems	☐	☐
Swelling	☐	☐
PSYCHIATRIC		
ADD	☐	☐
ADHD	☐	☐
Anxiety	☐	☐
Compulsive Acts	☐	☐
Depression	☐	☐
GASTROINTESTINAL		
Acid Reflux	☐	☐
Diarrhea	☐	☐
Gerd	☐	☐
Hiatal Hernia	☐	☐
Ulcers	☐	☐
GENITOURINARY		
Bladder	☐	☐
Kidney Failure	☐	☐
Prostate	☐	☐
Pregnant	☐	☐
1st Trimester	☐	☐
2nd Trimester	☐	☐
3rd Trimester	☐	☐
STD	☐	☐

NEUROLOGICAL	Y	N
Alzheimer's	☐	☐
Epilepsy	☐	☐
Headache	☐	☐
Migraine	☐	☐
Multiple Sclerosis	☐	☐
Parkinson's disease	☐	☐
Seizures	☐	☐
INTEGUMENTARY		
Acne	☐	☐
Breast Cancer	☐	☐
Eczema	☐	☐
Edema	☐	☐
Psoriasis	☐	☐
Rash	☐	☐
Rosacea	☐	☐
Skin Lesions	☐	☐
Skin Cancer	☐	☐
VASCULAR/CARDIOVASCULAR		
Elevated Cholesterol	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
ENDOCRINE		
Diabetes	☐	☐
Dialysis	☐	☐
Kidney Disease	☐	☐
Thyroid Disease	☐	☐
Other Glands	☐	☐
RESPIRATORY		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
Lung Cancer	☐	☐

	Y	N
Do you smoke? **If YES, how much?**		
Do you drink Alcohol? **If YES, how much?**		
Do you do recreational drugs? **If YES, how much?**		

LIST ANY MEDICATIONS YOU ARE TAKING

When was your last eye examination? _____

Are you a previous patient at this office? Y N

Are you interested in Contact Lenses? Y N

Have you worn them before? Y N

If YES, what type of lenses did you wear? _____

Have you previously worn glasses? Y N

What type of glasses do you wear?
SINGLE BIFOCAL TRIFOCAL PROGRESSIVE

Are you interested in Lasik Surgery? Y N

Are you interested in CRT Lenses? Y N