CROSS ROADS EYE CARE LLC
Family Optometry
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PATIENT MEDICAL HISTORY

Patient's Name: ______________________________ Date: ______________

Date of Birth: ______________________________ Age: ______________

Primary Care Physician: ______________________________

PERSONAL EYE HEALTH HISTORY: Do you have any of the following conditions?

	YES	NO		YES	NO		YES	NO
Blurred vision	____	____	Retina problem	____	____	Cataracts	____	____
Macular degen.	____	____	Cornea problem	____	____	Glaucoma	____	____
Double vision	____	____	Flashes/Floaters	____	____	Itching/burning	____	____
Dry eyes	____	____	Light Sensitivity	____	____	Loss of vision	____	____
Redness	____	____	Pain/soreness	____	____	Watering eyes	____	____
Discharge	____	____	Sty/chalazion	____	____	Eye twitch	____	____
Crossed/lazy eye	____	____	Eye injury	____	____	Other ______________		

Do you wear glasses? __________ How old are your current glasses? ______________

Do you wear contacts? __________ What brand/type of contact lens do you wear? ______________

Do you sleep in your contacts? __________ Date of last eye examination ______________

PERSONAL MEDICAL HISTORY: Have you ever been treated for or diagnosed with any of the following?

	YES	NO		YES	NO		YES	NO
Diabetes	____	____	Weight loss/gain	____	____	Asthma	____	____
High blood pressure	____	____	Anemia/bleeding	____	____	Chronic bronchitis	____	____
Thyroid problems	____	____	Allergies	____	____	Emphysema	____	____
Heart disease	____	____	Chronic cough	____	____	Diarrhea	____	____
Kidney/bladder	____	____	Dry throat/mouth	____	____	Constipation	____	____
Stroke	____	____	Headaches	____	____	Arthritis	____	____
Vascular disease	____	____	Migraines	____	____	Muscle/joint pain	____	____
Are you pregnant or nursing? ________			Psychiatric	____	____	Seizures	____	____
			Cancer	____	____			

FAMILY HISTORY: Has anyone in your immediate family ever been treated or diagnosed with any of the following?

	YES	NO		YES	NO		YES	NO
Diabetes	____	____	Cancer	____	____	Cataracts	____	____
Heart disease	____	____	Arthritis	____	____	Retinal disease	____	____
Thyroid problems	____	____	Blindness	____	____	Crossed/Lazy	____	____
High blood pressure	____	____	Glaucoma	____	____	Macular degen.	____	____

MEDICATIONS: Please list any medications you are now taking, including eye drops and over-the-counter medications.

____

____

Are you allergic to any medications?______ Please list: ______________________________

Do you smoke? ______________

Please list occupation and hobbies: ______________________________

FOR CHILDREN ONLY:

Current grade in school:______ School your child attends: ______________________________

Does your child do well in school? ______ Any developmental delays? ______ Any learning disorders or dyslexia?______

Has your child been diagnosed with ADD/ADHD?_______ Read at grade level? _______ On grade level in math? ______

FOR OFFICE USE ONLY: DATE UPDATED: ______________________ By