Eyecare Center of Madison

302 North Harth Ave
Madison, SD 57042
Phone: 605.256.6911
Fax: 605.256.9017

Eye Health and Medical History

Patient Name _____ **Exam Date** _____

Please check YES or NO for each listed Category or condition as it applies to you PERSONALLY.

Constitution	Yes	No
Developmental Disabilities		
Cancer		
Fatigue Syndrome		
HIV/AIDS		
Other_____		

Neurological	Yes	No
Multiple Sclerosis		
Epilepsy		
Cerebral Palsy		
Tumor		
Stroke		
Migraine		
Autism Spec. Disorder		
Other_____		

Psychiatric	Yes	No
Depression		
Attention Deficit		
Anxiety Disorder		
Bipolar Disorder		
Other_____		

Cardiovascular	Yes	No
High Blood Pressure		
Stroke/CVA		
Heart Disease		
Vascular Disease		
Cong. Heart Failure		
Other_____		

Respiratory	Yes	No
Cig. Smoker		
Asthma		
Bronchitis		
Emphysema		
Chronic Obstruction		
Sleep Apnea		
Other_____		

Gastrointestinal	Yes	No
Crohn's Disorder		
Colitis		
Ulcer		
Acid Reflux		
Celiac Disease		
Other_____		

ENT	Yes	No
Hearing Loss		
Sinusitis		
Dry Mouth		
Laryngitis		
Other_____		

Genital Urinary	Yes	No
Kidney Disease		
Prostate Disorder/Cancer		
Benign Prostate Hypertrophy		
Pregnant		
Nursing		
Herpes		
Chlamydia		
Other_____		

Muscle/Skeletal	Yes	No
Arthritis		
Osteoarthritis		
Fibromyalgia		
Muscular Dystrophy		
Anklosing Spondylitis		
Osteoporosis		
Gout		
Other_____		

Integumentary/Skin	Yes	No
Eczema		
Rosacea		
Psoriasis		
Cold Sores		
Shingles		
Other_____		

Endocrine	Yes	No
Type 2 Diabetes		
Type 1 Diabetes		
Thyroid Dysfunction		
Hormone Dysfunction		
Other_____		

Hem/Lymph	Yes	No
Anemia		
Large Blood Vol/Loss		
Ulcer		
High Cholesterol		
Other_____		

Continue on Reverse Side

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Eye Health and Medical History

Allergic/Imm.	Yes	No
Drug Allergies		
Environmental Allergies		
Rheum Arthritis		
Lupus		
Sjogren's Syndrome		
Other_____		

Social History	Yes	No
Drink Alcohol		
Current Smoker		
Chew Tobacco		
Former Tobacco User		
Illegal Drug User		

FAMILY Eye Health and Medical History			
Disease/Condition	Yes	No	Relation
Diabetes			
Glaucoma			
Macular Degeneration			
Cataracts/Cataract Surgery			
Crossed Eye			
Lazy Eye/Amblyopia			
Retinal Detachment			
Eye Injury			

Please List any other Family History info that may be pertinent to your exam:

_____

_____

_____

_____

Personal Ocular History	Yes	No
Glaucoma Suspect		
Glaucoma		
Cataract		
Macular Degeneration		
Ocular Surgery		
Patching		
Inflammatory Disorder		
Crossed Eye		
Lazy Eye		
Retinal Degeneration		
Retinal Hole		
Retinal Detachment		
Keratoconus		

Please List any other Ocular History info that may be pertinent to your exam:

_____

_____

_____

_____

My Medications and Supplements

Please list all medications, supplements and eye products you are currently using (prescription and non-prescription); or, a printed/written list may be attached.

Prescription Medication/Supplement/OTC Medications	Purpose

Drug Allergies ☐ Yes ☐ None Know

*Please list any **medications** you are allergic to:*

_____ _____

_____ _____

_____ _____

Other Allergies ☐ Yes ☐ None Know

*Please list any **other** allergies you have: e.g. Nuts, Bees*

_____ _____

_____ _____

_____ _____