

**MEDICAL HISTORY**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Date of Last Medical Exam: \_\_\_\_\_

Date of Last Vision Exam: \_\_\_\_\_ Dominant Hand:  Right  Left  Ambidextrous

Allergies to Medicines or other Substances: \_\_\_\_\_

Current Medications (Prescription or Otherwise): \_\_\_\_\_

Recent Hospitalizations or Surgeries: \_\_\_\_\_

**SYSTEMS HISTORY**

*Indicate if you have ever had issues (past or present) within any of the following areas:*

	Yes	No		Yes	No
<b>Eyes</b>			<b>Vascular/Heart</b>		
Complete loss of vision	___	___	Diabetes	___	___
Blurred vision	___	___	High blood pressure	___	___
Double vision	___	___	Heart pain	___	___
Eye injury	___	___	<b>Neurological</b>		
Eye surgery	___	___	Headaches	___	___
Floaters/Flashes	___	___	Migraines	___	___
Glare/Halos	___	___	Seizures	___	___
Crossed or lazy eye	___	___	<b>Respiratory</b>		
Cataracts	___	___	Asthma	___	___
Glaucoma	___	___	Chronic bronchitis	___	___
Eye pain or soreness	___	___	Emphysema	___	___
Retinal disease	___	___	<b>Skin</b>	___	___
<b>Endocrine</b>			<b>Psychiatric</b>	___	___
Thyroid	___	___	<b>Gastrointestinal</b>		
<b>Bones/Joints/Muscles</b>			Diarrhea	___	___
Rheumatoid arthritis	___	___	<b>Ear/Nose/Throat/Mouth</b>		
Joint pain	___	___	Allergies/Hay fever	___	___
<b>Hematologic</b>			<b>Genitourinary</b>		
Anemia	___	___	Kidney/Bladder/Genital	___	___
			<b>Other</b> _____		

**SOCIAL HISTORY**

Do you use tobacco products? \_\_\_ \_\_\_

Do you drink alcohol? \_\_\_ \_\_\_

How much? \_\_\_\_\_

Do you use illegal drugs? \_\_\_ \_\_\_

Have you been exposed or infected with:

Gonorrhea  Hepatitis  HIV  Syphilis

**FAMILY HISTORY**

*Indicate any family history (parents, grandparents, siblings, children – living or deceased) for the following:*

<b>Ocular Conditions</b>	Yes	No	<b>Systemic Conditions</b>	Yes	No
Blindness	___	___	Diabetes	___	___
Crossed eyes	___	___	High blood pressure	___	___
Glaucoma	___	___	Cancer	___	___
Macular degeneration	___	___	Heart Disease	___	___
Retinal detachment	___	___			

Reviewed by (Doctor's Signature): \_\_\_\_\_

By signing this form, I consent to treatment for myself and/or on behalf of the minor for which this information pertains. I give permission for the doctor/s to examine, diagnose and initiate treatment as deemed appropriate. I further attest that I am the parent or legal guardian of minor and have the authority to authorize care and treatment.

**Patient or Guardian Signature** \_\_\_\_\_