

MEDICAL HISTORY

Name _____ Date _____/_____/_____
 Address _____ Phone _____
 City _____ State _____ Zip _____ Cell Phone _____
 Guardian (if applicable) _____ Email _____
 Birthdate _____/_____/_____ Last Eye Exam _____/_____/_____ Occupation _____
 Do you have vision insurance? No Yes If yes, insurance carrier _____
 Do you have health insurance? No Yes If yes, insurance carrier _____
 Do you have medicare? No Yes **Primary Care Physician:** _____

Medical History

List medications you take (including oral contraceptives, aspirin, over-the-counter medications, and home remedies)

Check any of the following that you have had: age-related macular degeneration inflammatory disorder
 cataract strabismus kerataconus amblyopia glaucoma suspect glaucoma surgery
 retinal degeneration/hole/detachment patching eye injury

Are you pregnant and/or nursing? No Yes
 Do you wear glasses? No Yes If yes, how old is your present pair of lenses? _____
 Do you wear contact lenses? No Yes If yes, what brand? _____
 Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? No Yes

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	Yes	No	?	Relationship
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Strabismus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma Suspect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Severe Myopia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Severe Hyperopia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Social History – This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I prefer to discuss my Social History information directly with the doctor.

Do you drive? No Yes If yes, do you have visual difficulty when driving? No Yes If yes, please describe:

Do you use tobacco products? No Yes If yes, type/amount/how long _____
 Are you a Former Smoker Current Occasional Smoker Current Everyday Smoker
 Do you drink alcohol? No Yes If yes, type/amount/how long _____
 Do you use illegal drugs? No Yes If yes, type/amount/how long _____

Name _____ Date _____/_____/_____

Review of Systems Do you currently, or have you ever had, any problems in the following areas:

	Yes	No
Eyes		
Itching	<input type="checkbox"/>	<input type="checkbox"/>
Diplopia	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>
Mattering	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>
Photophobia	<input type="checkbox"/>	<input type="checkbox"/>
Red	<input type="checkbox"/>	<input type="checkbox"/>
Floater	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Sharpness	<input type="checkbox"/>	<input type="checkbox"/>
Flashes	<input type="checkbox"/>	<input type="checkbox"/>
Tearing	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Constitutional		
Developmental Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Ear, Nose, Mouth, Throat		
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Laryngitis	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Neurological		
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/CVA	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Psychiatric		
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Vascular/Cardiovascular		
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Respiratory		
Cigarette Smoker	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Respiratory (continued)		
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Gastrointestinal		
Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Genitourinary		
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
STD - Herpetic/Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Disease/Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant/Nursing	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Musculoskeletal		
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Ankylosing Spondylitis	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Integumentary		
Herpes Simplex/Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>
Herpes Zoster/Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Rosacea	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Endocrine		
Diabetes Type II	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Hormonal Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Type I	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Hematologic/Lymphatic		
Large Volume Blood Loss	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Allergic/Immunologic		
Environmental Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Drug Allergies	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what drug? _____		
Sjogrens Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

If you answered yes to any of the above, or have a condition not listed, please explain:

Doctor's Signature _____ Date _____/_____/_____