MEDICAL HISTORY

Name _____ Age _____ Birthdate _____/_____/_____

Address _____ City _____ State _____ Zip _____

Guardian (if applicable) _____ Phone (_____)_____ Cell Phone (_____)_____

Social Security _____-_____-_____ Occupation _____ Email _____

Last Eye Exam _____/_____/_____ Last Physical Exam _____/_____/_____ PCP _____

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 Language_____ Race_____ Ethnicity_____

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 ❒ none

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	❒	❒	❒	_____
Diabetes	❒	❒	❒	_____
Hypertension	❒	❒	❒	_____
Cancer	❒	❒	❒	_____
Strabismus	❒	❒	❒	_____
Cataract	❒	❒	❒	_____
Glaucoma Suspect	❒	❒	❒	_____
Amblyopia	❒	❒	❒	_____
Severe Myopia	❒	❒	❒	_____
Macular Degeneration	❒	❒	❒	_____
Retinal Detachment/Disease	❒	❒	❒	_____
Glaucoma	❒	❒	❒	_____
Severe Hyperopia	❒	❒	❒	_____
Other	❒	❒	❒	_____

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	❒	❒
Diplopia	❒	❒
Burning	❒	❒
Mattering	❒	❒
Loss of Vision	❒	❒
Photophobia	❒	❒
Red	❒	❒
Floaters	❒	❒
Loss of Sharpness	❒	❒
Flashes	❒	❒
Tearing	❒	❒
Other_____		
Constitutional		
Developmental Disorders	❒	❒
Cancer	❒	❒
Fatigue Syndrome	❒	❒
Other_____		
Ear, Nose, Mouth, Throat		
Sinusitus	❒	❒
Dry Mouth	❒	❒
Hearing Loss	❒	❒
Laryngitis	❒	❒
Other_____		
Neurological		
Epilepsy	❒	❒
Multiple Seizures	❒	❒
Tumor	❒	❒
Cerebral Palsy	❒	❒
Stroke/CVA	❒	❒
Migraine	❒	❒
Other_____		
Psychiatric		
Depression	❒	❒
Bipolar	❒	❒
Anxiety	❒	❒
Attention Deficit	❒	❒
Other_____		
Vascular/Cardiovascular		
Vascular Disease	❒	❒
Stroke	❒	❒
Heart Disease	❒	❒
High Blood Pressure	❒	❒
Congestive Heart Failure	❒	❒
Other_____		
Respiratory		
Cigarette Smoker	❒	❒
Bronchitis	❒	❒
COPD	❒	❒
Emphysema	❒	❒
Asthma	❒	❒

	Yes	No
Respiratory (continued)		
Sleep Apnea	❒	❒
Other_____		
Gastrointestinal		
Celiac Disease	❒	❒
Crohn's Disease	❒	❒
Ulcer	❒	❒
Colitis	❒	❒
Acid Reflux	❒	❒
Other_____		
Genitourinary		
Kidney Disease	❒	❒
STD - Herpetic/Chlamydia	❒	❒
Prostate Disease/Cancer	❒	❒
Pregnant/Nursing	❒	❒
Other_____		
Musculoskeletal		
Arthritis	❒	❒
Ankylosing Spondylitis	❒	❒
Fibromyalgia	❒	❒
Muscular Dystrophy	❒	❒
Osteoarthritis	❒	❒
Gout	❒	❒
Other_____		
Integumentary		
Herpes Simplex/Cold Sores	❒	❒
Herpes Zoster/Shingles	❒	❒
Rosacea	❒	❒
Psoriasis	❒	❒
Eczema	❒	❒
Other_____		
Endocrine		
Diabetes Type II	❒	❒
Thyroid Dysfunction	❒	❒
Hormonal Dysfunction	❒	❒
Diabetes Type I	❒	❒
Other_____		
Hematologic/Lymphatic		
Large Volume Blood Loss	❒	❒
Anemia	❒	❒
Ulcer	❒	❒
High Cholesterol	❒	❒
Other_____		
Allergic/Immunologic		
Environmental Allergies	❒	❒
Lupus	❒	❒
Rheumatoid Arthritis	❒	❒
Drug Allergies	❒	❒
Sjogrens Syndrome	❒	❒
Other_____		

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

_____

_____

_____

Doctor's Signature_____ Date _____/_____/_____