Patient Medical History

Name: _____ Date: _____ Age: _____

Birth Date: _____ Last eye exam: ___/____ Last Medical Exam: ___/____

Have you had any **EYE** Surgeries? ☐ No ☐ Yes please check:

☐ LASIK ☐ CATARACT ☐ EYE TURN ☐ RK ☐ GLAUCOMA

☐ LASER FOR DIABETES OTHER: _____

Which eye was this on? ☐ Right eye ☐ Left eye ☐ Both eyes

Please check any conditions that apply to YOU:

Ocular History	**Right**	**Left**	**Ocular History**	**Right**	**Left**
Glaucoma	☐	☐	Distorted/Halos	☐	☐
Retinal Disease	☐	☐	Side vision Loss	☐	☐
Keratoconus	☐	☐	Double vision	☐	☐
Cataracts	☐	☐	Dryness	☐	☐
Eye Turn	☐	☐	Sandy feeling	☐	☐
Lazy Eye	☐	☐	Eyes Itch	☐	☐
Eye Infection w/ loss of vision	☐	☐	Mucous Discharge	☐	☐
Recurring eye infections	☐	☐	Redness	☐	☐
Drooping eyelids	☐	☐	Burning	☐	☐
Floaters in vision	☐	☐	Foreign body sensation	☐	☐
Tired eyes	☐	☐	Light sensitivity	☐	☐
Vision loss	☐	☐	Eye pain	☐	☐
Vision Blurred	☐	☐	Sties/Chalazion	☐	☐

Medical History	**Yes**	**No**	**Medical History**	**Yes**	**No**
Pregnant or nursing	☐	☐	Hypertension	☐	☐
Arthritis	☐	☐	Kidney Disease	☐	☐
Asthma	☐	☐	Lung Disease	☐	☐
Cancer	☐	☐	Multiple Sclerosis	☐	☐
Diabetes	☐	☐	Thyroid	☐	☐
Heart Disease	☐	☐	HIV	☐	☐
High Cholesterol	☐	☐			

Please List any Medications you are currently taking: _____

_____

Do you have any **Allergies to medications**? ☐ No ☐ Yes, please list: _____

_____

Patient Signature: _____ **Date**: _____

Family History

Please check any family history of the following conditions. If family history is unknown please check here ☐

	Father	Mother	Sibling	Grandparent
Blindness	_____	_____	_____	_____
Cataract	_____	_____	_____	_____
Crossed Eyes	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____
Macular Degeneration	_____	_____	_____	_____
Retinal Detachment Disease	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____
Lupus	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____

Do you drive? ☐ No ☐ Yes Do you have difficulty when driving? ☐ No ☐ Yes
Explain: _____

Tobacco? ☐ No ☐ Yes, Quantity? _____ How Long? _____
Alcohol? ☐ No ☐ Yes, Quantity? _____ How Long? _____

Review of Systems (About you only)

CONSTITUTIONAL	YES	NO
Weight Loss	☐	☐
Weight gain	☐	☐
EAR/NOSE/MOUTH	**YES**	**NO**
Coughing	☐	☐
Stuffy Nose	☐	☐
Hay Fever	☐	☐
Sinus Congestion	☐	☐
Dry Mouth	☐	☐
CARDIOVASCULAR	**YES**	**NO**
Heart Disease	☐	☐
High cholesterol	☐	☐
Murmur	☐	☐
Stent	☐	☐
RESPIRATORY	**YES**	**NO**
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
Lung cancer	☐	☐
Tuberculosis	☐	☐
GASTROINTESTINAL	**YES**	**NO**
Diarrhea	☐	☐
Constipation	☐	☐

GENITOURINARY	YES	NO
Kidney stones	☐	☐
STD	☐	☐
MUSCULOSKETAL	**YES**	**NO**
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
INTEGUMENTARY	**YES**	**NO**
Eczema	☐	☐
Psoriasis	☐	☐
NEUROLOGICAL	**YES**	**NO**
Dizziness/Vertigo	☐	☐
Fainting	☐	☐
Seizures	☐	☐
Migraines	☐	☐
Numbness	☐	☐
Paralysis	☐	☐
Tremor	☐	☐
PSYCHIATRIC	**YES**	**NO**
Memory loss	☐	☐
Depression	☐	☐
Dementia	☐	☐
Nervousness	☐	☐

HEMATOLOGICAL	YES	NO
Anemia	☐	☐
Bleeding problems	☐	☐
Leukemia	☐	☐

Other: _____

Computer usage? ☐ ☐
Hours per day? _____

Contact Lenses

Do you wear Contacts:	**YES**	**NO**
	☐	☐

What brand do you wear now?

_____

Do you like them? _____

What is your contact lens prescription? ☐ Unknown

Right: _____ Left: _____