MEDICAL HISTORY

Name _____ Date ____/____/_____
Guardian (if applicable) _____ Phone _____
Address _____ Work Phone _____
City _____ State_____ Zip _____ Cell Phone _____
Date of Birth____/____/_____ Employment Status _____
Social Security Number _____ Employer _____
Marital Status _____
Last Eye Exam ____/____/_____

IS IT OKAY TO TEXT YOU ABOUT FUTURE VISITS? ❑ No ❑ Yes

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

Medical History

Do you have any allergies to medication? ❑ No ❑ Yes
If yes, explain _____

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

List all major injuries that you have had –
(Crossed eyes, lazy eye, drooping eyelid, glaucoma, cataracts, retinal disease, eye infections or 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, how old is your present pair of lenses? _____
Type of contact lenses: ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other Are they comfortable? ❑

Family History

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

Disease/Condition	No	Yes	?	Relationship
Blindness	❑	❑	❑	
Cataract	❑	❑	❑	
Crossed Eyes	❑	❑	❑	
Glaucoma	❑	❑	❑	
Macular Degeneration	❑	❑	❑	
Retinal Detachment/Disease	❑	❑	❑	
Arthritis	❑	❑	❑	
Cancer	❑	❑	❑	
Diabetes	❑	❑	❑	
Heart Disease	❑	❑	❑	
Kidney Disease	❑	❑	❑	
Lupus	❑	❑	❑	
Thyroid Disease	❑	❑	❑	
Other	❑	❑	❑	

Please turn over to fill out your history.

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 any nutritional supplements? ❒ No ❒ Yes If yes, type _____

Do you use tobacco products? ❒ No ❒ Yes If yes, type/amount/how long _____

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 _____

Have you ever been exposed to or infected with: ❒ Gonorrhea ❒ Hepatitis ❒ HIV ❒ Syphilis

Review of Systems

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

	No	Yes	?
Constitutional			
Fever, Weight Loss/Gain	❒	❒	❒
Integumentary			
Skin	❒	❒	❒
Neurological			
Headaches	❒	❒	❒
Migraines	❒	❒	❒
Seizures	❒	❒	❒
Eyes			
Loss of Vision	❒	❒	❒
Blurred Vision	❒	❒	❒
Distorted Vision/Halos	❒	❒	❒
Loss of Side Vision	❒	❒	❒
Double Vision	❒	❒	❒
Dryness	❒	❒	❒
Mucous Discharge	❒	❒	❒
Redness	❒	❒	❒
Sandy or Gritty Feeling	❒	❒	❒
Itching	❒	❒	❒
Burning	❒	❒	❒
Foreign Body Sensation	❒	❒	❒
Excess Tearing/Watering	❒	❒	❒
Glare/Light Sensitivity	❒	❒	❒
Eye Pain or Soreness	❒	❒	❒
Chronic Infection of Eye or Lid	❒	❒	❒
Sties or Chalazion	❒	❒	❒
Flashes/Floaters in Vision	❒	❒	❒
Tired Eyes	❒	❒	❒
Endocrine			
Thyroid/Other Glands	❒	❒	❒

	No	Yes	?
Ear, Nose, Mouth, Throat			
Allergies/Hay Fever	❒	❒	❒
Sinus Congestion	❒	❒	❒
Runny Nose	❒	❒	❒
Post-Nasal Drip	❒	❒	❒
Chronic Cough	❒	❒	❒
Dry Throat/Mouth	❒	❒	❒
Respiratory			
Asthma	❒	❒	❒
Chronic Bronchitis	❒	❒	❒
Emphysema	❒	❒	❒
Vascular/Cardiovascular			
Diabetes	❒	❒	❒
Heart Pain	❒	❒	❒
High Blood Pressure	❒	❒	❒
Vascular Disease	❒	❒	❒
Gastrointestinal			
Chronic Diarrhea	❒	❒	❒
Chronic Constipation	❒	❒	❒
Genitourinary			
Genitals/Kidney/Bladder	❒	❒	❒
Bones/Joints/Muscles			
Rheumatoid Arthritis	❒	❒	❒
Muscle Pain	❒	❒	❒
Joint Pain	❒	❒	❒
Lymphatic/Hematologic			
Anemia	❒	❒	❒
Bleeding Problems	❒	❒	❒
Allergic/Immunologic	❒	❒	❒
Psychiatric	❒	❒	❒

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

_____

_____

_____

_____

_____

Doctor's Signature _____ **Date** ___/___/____