MEDICAL HISTORY / REVIEW OF SYSTEMS

Name (Legal/Full): _____ Today's Date: ____ / ____ / ____

Address: _____ Home Phone: _____

City, State: _____ Zip Code: _____ Cell Phone: _____

Guardian(s) (If Applicable): _____

Birth Date: ____ / ____ / ____ Social Security # ____ / ____ / ____

Email Address : _____

MEDICAL HISTORY

Date of Last Medical Exam: _____ Name of Primary Care Doctor: _____

Do you have Diabetes? ____ Y ____ N Date of Last Dilated Diabetic Exam? _____ What was your last A1C? _____

What is your general health status? ____ Excellent ____ Good ____ Fair ____ Poor

List all medications you are taking. _____

Do you have allergies to any medications? ____ Yes ____ No If yes, explain: _____

Do you have general allergies? ____ Yes ____ No Allergic to what? _____

What Happens? _____

List all major illnesses, injuries, surgeries and/or hospitalizations you have had. _____

Are you pregnant? ____ Yes ____ No Are you nursing? ____ Yes ____ No

OCULAR HISTORY

Date of Last Eye Exam: _____ Do you wear eyeglasses? ____ Yes ____ No

Do you wear contact lenses? ____ Yes ____ No If yes, what type? _____

If yes, which solutions/care system? _____

Current eye drops. _____

List all current or past eye diseases, eye injuries or eye surgeries. _____

FAMILY HISTORY

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

Disease / Condition			Relationship To You
Blindness	____ Yes	____ No	_____
Cataract	____ Yes	____ No	_____
Crossed Eyes	____ Yes	____ No	_____
Glaucoma	____ Yes	____ No	_____
Macular Degeneration	____ Yes	____ No	_____
Retinal Detachment / Disease	____ Yes	____ No	_____
Arthritis	____ Yes	____ No	_____
Cancer	____ Yes	____ No	_____
Diabetes	____ Yes	____ No	_____
Heart Disease	____ Yes	____ No	_____
High Blood Pressure	____ Yes	____ No	_____
Stroke	____ Yes	____ No	_____
Kidney Disease	____ Yes	____ No	_____
Lupus	____ Yes	____ No	_____
Thyroid Disease	____ Yes	____ No	_____
Other _____	____ Yes	____ No	_____

TURN OVER AND CONTINUE ON OTHER SIDE

SOCIAL HISTORY

This information is a protected part of your medical record and is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Does your vision limit activities of daily living? (driving, reading, working, etc.) ____ Yes ____ No

If yes, please describe. _____

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

Do you drink alcohol? ____ Yes ____ No If yes, type/amount/how long? _____

Do you use illicit drugs? ____ Yes ____ No If yes, type/amount/how long? _____

Please note if you have ever been exposed to or infected with:

____ HIV ____ Hepatitis ____ Tuberculosis ____ Chlamydia ____ Gonorrhea ____ Syphilis

REVIEW OF SYSTEMS

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

			If Yes, Please Explain
EYES			
Loss of Vision	____ Yes	____ No	_____
Blurred Vision	____ Yes	____ No	_____
Distorted Vision / Halos	____ Yes	____ No	_____
Loss of Side Vision	____ Yes	____ No	_____
Double Vision	____ Yes	____ No	_____
Dryness	____ Yes	____ No	_____
Mucous Discharge	____ Yes	____ No	_____
Redness	____ Yes	____ No	_____
Sandy or Gritty Feeling	____ Yes	____ No	_____
Itching	____ Yes	____ No	_____
Burning	____ Yes	____ No	_____
Foreign Body Sensation	____ Yes	____ No	_____
Excess Tearing / Watering	____ Yes	____ No	_____
Glare / Light Sensitivity	____ Yes	____ No	_____
Eye Pain or Soreness	____ Yes	____ No	_____
Chronic Infection of Eye or Lid	____ Yes	____ No	_____
Sties or Chalazion	____ Yes	____ No	_____
Flashes / Floaters in Vision	____ Yes	____ No	_____
Tired Eyes	____ Yes	____ No	_____
CARDIOVASCULAR (heart, blood vessels)	____ Yes	____ No	_____
RESPIRATORY (lungs/breathing)	____ Yes	____ No	_____
GASTROINTESTINAL (stomach/intestines)	____ Yes	____ No	_____
GENITOURINARY (genitals/kidney/bladder)	____ Yes	____ No	_____
MUSCULOSKELETAL (muscles/joints)	____ Yes	____ No	_____
INTEGUMENT (skin/breast)	____ Yes	____ No	_____
PSYCHIATRIC (Anxiety/Depression)	____ Yes	____ No	_____
NEUROLOGICAL	____ Yes	____ No	_____
ENDOCRINE (hormones/glands)	____ Yes	____ No	_____
HEMATOLOGIC/IMMUNOLOGIC (blood)	____ Yes	____ No	_____
SEASONAL ALLERGIES (hay fever, etc)	____ Yes	____ No	_____

_____ ____ / ____ / ____

Patient or Legal Guardian Signature Date

_____ ____ / ____ / ____

Doctor's Signature Date