MEDICAL HISTORY

Name ______________________________ Date ______/______/______
Address ______________________________ Phone ______________________________
City ______________________ State ______ Zip ______ Cell Phone ______________________________
Guardian (if applicable) ______________________________ Email ______________________________
Birthdate _____/_____/_____ Social Security # ______________________ Employer/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

Medical History

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

____
____
____
____

List all major injuries, surgeries, and/or hospitalizations:

____
____

Check any of the following that you have had: ❒ macular degeneration ❒ inflammatory disorder
❒ cataract ❒ crossed eyes ❒ kerataconus ❒ lazy eye ❒ glaucoma suspect or glaucoma ❒ eye surgery
❒ retinal degeneration/hole/detachment ❒ patching ❒ eye injury

Are you pregnant and/or nursing? ❒ No ❒ Yes If yes, circle one
Do you wear glasses? ❒ No ❒ Yes Do you wear contact lenses? ❒ No ❒ Yes
Last Eye Exam: ______________ By Whom? ______________
Name of Medical Doctor ______________________________

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/Crossed Eyes	❒	❒	❒	______________
Cataract	❒	❒	❒	______________
Amblyopia/Lazy Eye	❒	❒	❒	______________
Macular Degeneration	❒	❒	❒	______________
Retinal Detachment/Disease	❒	❒	❒	______________
Glaucoma or Glaucoma Suspect	❒	❒	❒	______________

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 ______________________________

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– OVER –

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

Eyes	Yes	No
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Double Vision	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Itching	☐	☐
Burning	☐	☐
Excess Tearing/Watering	☐	☐
Dryness	☐	☐
Light Sensitivity	☐	☐
Floaters	☐	☐
Flashes	☐	☐
Other____________		
Constitutional		
Developmental Disorders	☐	☐
Cancer	☐	☐
Chronic Fatigue Syndrome	☐	☐
Other____________		
Ear, Nose, Mouth, Throat		
Sinusitis	☐	☐
Dry Mouth	☐	☐
Laryngitis	☐	☐
Other____________		
Neurological		
Epilepsy	☐	☐
Multiple Seizures	☐	☐
Brain Tumor	☐	☐
Cerebral Palsy	☐	☐
Headaches	☐	☐
Migraines	☐	☐
Other____________		
Psychiatric		
Depression	☐	☐
Bipolar	☐	☐
Anxiety	☐	☐
Attention Deficit	☐	☐
Other____________		
Vascular/Cardiovascular		
Vascular Disease	☐	☐
Stroke	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Congestive Heart Failure	☐	☐
Other____________		

Respiratory	Yes	No
Chronic Bronchitis	☐	☐
COPD	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Sleep Apnea	☐	☐
Other____________		
Gastrointestinal (Digestive)		
Crohn's Disease	☐	☐
Chronic Diarrhea	☐	☐
Chronic Constipation	☐	☐
Other____________		
Genitourinary		
Kidney Disease	☐	☐
STD - Herpetic/Chlamydia	☐	☐
Prostate Disease/Cancer	☐	☐
Other____________		
Musculoskeletal		
Arthritis	☐	☐
Fibromyalgia	☐	☐
Muscular Dystrophy	☐	☐
Other____________		
Integumentary (Skin)		
Rosacea	☐	☐
Psoriasis	☐	☐
Eczema	☐	☐
Other____________		
Endocrine		
Diabetes Type II	☐	☐
Thyroid Dysfunction	☐	☐
Hormonal Dysfunction	☐	☐
Diabetes Type I	☐	☐
Other____________		
Hematologic/Lymphatic		
Anemia	☐	☐
Bleeding Problems	☐	☐
High Cholesterol	☐	☐
Other____________		
Allergic/Immunologic		
Environmental Allergies	☐	☐
Lupus	☐	☐
Rheumatoid Arthritis	☐	☐
Drug Allergies	☐	☐
If yes, what drug?____________		
Sjogrens Syndrome	☐	☐
Multiple Sclerosis	☐	☐
Other____________		

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

____

____

____

____

____

Doctor's Signature______________________________ Date______/______/______