

MEDICAL HISTORY FORM

NAME _____ AGE _____ DATE _____

REFERRING DOCTOR OR PERSON _____

EYE HISTORY: Do You Wear Glasses _____ Contact Lenses _____ Date of Last Eye Exam _____

EYE PROBLEMS: Please Check any of the following problems that you have.

- | | | |
|---|--|---|
| <input type="checkbox"/> Blurred or Poor Vision | <input type="checkbox"/> Poor Night Vision | <input type="checkbox"/> Gritty Sensation |
| <input type="checkbox"/> Trouble Reading Signs | <input type="checkbox"/> Glare From Lights | <input type="checkbox"/> Tearing |
| <input type="checkbox"/> Poor Depth Perception | <input type="checkbox"/> Halos Around Lights | <input type="checkbox"/> Itching or Burning |
| <input type="checkbox"/> Trouble Identifying Colors | <input type="checkbox"/> See Spots or Floaters | <input type="checkbox"/> Eye Pain |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> See Light Flashes | <input type="checkbox"/> Redness or bloodshot |
|
<input type="checkbox"/> OTHER _____ | | |

PLEASE MARK ANY CONDITION YOU OR A BLOOD RELATIVE HAVE. INDICATE RELATIONSHIP.

YOU	RELATIVE		YOU	RELATIVE	
___	_____	Dry Eyes	___	_____	Macular Degeneration
___	_____	Glaucoma	___	_____	Retinal Detachment
___	_____	Cataracts	___	_____	OTHER
			___	_____	CHECK IF NONE

HAVE YOU EVER HAD EYE SURGERY (including laser)? YES NO

If Yes, describe & give dates: _____

EYE MEDICATIONS: Please List: _____

DRUG ALLERGIES: NONE or **Please List:**

MEDICAL HISTORY: Medical Doctor _____ Location _____ Phone # _____

Please mark any condition you or a blood relative have/indicate relationship: **CHECK HERE IF NONE** _____

YOU	RELATIVE		YOU	RELATIVE	
___	_____	High Blood Pressure	___	_____	Heart Problems (Arrhythmia, Angina, Congestive Heart Failure)
___	_____	Diabetes	___	_____	Lung Problems (Sarcoidosis, Emphysema, COPD, Asthma)
___	_____	Stroke	___	_____	Thyroid Problems
___	_____	Arthritis			
___	_____	Ulcers			
___	_____	Others: PLEASE LIST			

LIST ALL MEDICINES: INCLUDE DOSAGE (i.e. mg) & HOW MANY TIMES TAKEN DAILY.

- 1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

List any non-ocular surgery and date:- _____

SOCIAL HISTORY: **Smoke** NO YES (Cigarettes, Cigars, Pipe) _____ # per day. List any drugs: _____
Alcohol NO YES (Beer, Wine, Liquor) _____ Social or Indicate Daily Consumption _____

REVIEW OF SYSTEMS: (Circle or list problems you have in any area) **CHECK HERE IF NONE:** _____

CONSTITUTIONAL & INTEGUMENTARY: Fever, Weight Loss, Rash, Skin Disease _____

HEAD/NECK: Sinus Problems, Post-Nasal Drip, Runny Nose, Dry Mouth, Hearing Loss _____

RESPIRATORY: Cough, Bronchitis, Shortness of Breath, Asthma, Emphysema, COPD _____

CARDIOVASCULAR: Chest Pain, Congestive heart Failure, Irregular Rhythm _____

GASTROINTESTINAL: Vomiting, Ulcers, Diarrhea, Bloody Stools _____

GENITOURINARY: Genital Ulcers, Discharge, Kidney Stones, Blood in Urine _____

ALLERGIC/IMMUNOLOGIC & BLOOD/LYMPHATIC: Seasonal allergies, Hay Fever, _____

Neurologic, Neurologic, Psychiatric & Musculoskeletal: Headache, Migranes, Paralysis, Joint aches _____