

**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 |
| <br><input type="checkbox"/> <b>OTHER</b> _____     |  |   |

**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
			___	_____	<b>CHECK IF NONE</b>

**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 \_\_\_\_\_