

## MEDICAL HISTORY

PLEASE PRINT

NAME \_\_\_\_\_ DATE \_\_\_\_\_

### PAST OCULAR HISTORY

Date of last eye exam? \_\_\_\_\_

Do you or any blood relative have any of the following?

(Mark "S" for Self "R" for relative.)

\_\_\_\_ blindness                      \_\_\_\_ macular degeneration                      \_\_\_\_ glaucoma  
\_\_\_\_ retinal detachment                      \_\_\_\_ amblyopia (lazy eye)                      \_\_\_\_ cataract  
\_\_\_\_ strabismus (mis-aligned eyes)

Have you ever had eye surgery? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe: \_\_\_\_\_

Have you ever had an eye injury? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please describe: \_\_\_\_\_

Do you have an optometrist? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please list: \_\_\_\_\_

Do you wear glasses or contact lenses? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, for how long? \_\_\_\_\_

Do you drive? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you have visual difficulty when driving? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you have problems with night vision? \_\_\_\_\_ Yes \_\_\_\_\_ No

### PRESENT OR PAST MEDICAL HISTORY/FAMILY HISTORY

Are you now being treated for or ever been treated for any medical conditions:

(Mark "S" for Self, "R" for Relative.)

\_\_\_\_ arthritis                      \_\_\_\_ cancer                      \_\_\_\_ diabetes  
\_\_\_\_ heart disease                      \_\_\_\_ high blood pressure                      \_\_\_\_ stroke  
\_\_\_\_ high cholesterol                      \_\_\_\_ thyroid disease  
\_\_\_\_ other (please list) \_\_\_\_\_

List all: Medications you are currently taking (including eye drops, Vitamins, birth control) \_\_\_\_\_

List all Allergies: Meds, Latex or Other \_\_\_\_\_

Please list all surgical procedures you have had in the past: \_\_\_\_\_

**REVIEW OF SYSTEMS:**

Do you currently have or ever been treated for the following problems. Yes NO Explain

Chronic Fever, Unexpected weight loss/gain, fatigue	___	___	___
Ear/nose/throat problems (hearing loss, sinus problems, sore throat)	___	___	___
Heart problems (chest pain, irregular heart beat)	___	___	___
Respiratory problems ( shortness of breath, wheezing, coughing)	___	___	___
Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomiting)	___	___	___
Urinary problems (pain or discomfort, blood in urine)	___	___	___
Skin problems (rashes, excessive dryness)	___	___	___
Musculoskeletal problems (muscle aches, joint pain, swollen joints)	___	___	___
Neurologic problems (numbness, weakness, headaches, paralysis)	___	___	___
Psychiatric problems (depression, anxiety)	___	___	___

**SOCIAL HISTOR**

Do you drink alcohol? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If YES, how often? \_\_\_\_\_  
Current occupation \_\_\_\_\_  
Do you smoke? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If YES, how many packs a day \_\_\_\_\_  
Are you pregnant? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Have you ever had a blood transfusion? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Have you ever had hepatitis? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Have you ever been in intimate contact with a person who had a sexually transmitted disease? \_\_\_\_\_ Yes \_\_\_\_\_ No

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_

History reviewed \_\_\_\_\_ No changes \_\_\_\_\_ Additions as noted above \_\_\_\_\_

**FORM MUST BE COMPLETELY FILLED OUT AND SIGNED FOR INSURANCE PAYMENT**