Medical History

Miss. Mrs. Ms. Mr. Dr. Rev.

Full Name: ____

Address: ____

City: ___________________ ST: ________ ZIP: _____________

Email Address: ____

Occupation: ____

Employer: ____

Medical Doctor: ____

Previous Eye Doctor:____________________________________

Single Married Divorced Separated Widowed

Birthdate: _______/_______/___________

Social Security #: _______-_______-_______

Home Phone: ____

Cell Phone: ____

Work Phone: ____

Last Medical Exam: _______/_______/__________

Last Eye Exam: _______/_______/__________

Parent/Guardian: ____

Do you prefer **Text** **Call (home / Cell)** **Email**

Have you or a family member been diagnosed with the following? Please circle

Diabetes No Patient Mother Father Sibling Grandparent

Year Diagnosed ______________ Last A1C ___________

High Blood Pressure No Patient Mother Father Sibling Grandparent

Thyroid No Patient Mother Father Sibling Grandparent

Cardiovascular Disease No Patient Mother Father Sibling Grandparent

Cancer No Patient Mother Father Sibling Grandparent

Type _________________________

Are you pregnant or nursing? YES NO

Please list all medications *Note-- please attach a list if extensive

____

Please list all allergies

____

Please list all major surgeries

____

Do you smoke? YES NO Occasionally Former Quit date _________________

Smokeless tobacco? YES NO Occasionally Former Quit date ___________________

Alcohol? YES NO Socially Occasional Daily

General

Headaches

Unexplained Weight gain/loss

ENT

Hearing problems

Sinusitis

Genitourinary

Kidney disease

Other

Cardiovascular

Heart attack

Stroke

Other

Pulmonary

Shortness of breath

Chronic Cough

Other

Musculoskeletal

Arthritis

Other

Gastrointestinal

IBS/Crohn's disease/Colitis

Colon Cancer

Other

Endocrine

Increased thirst

Other

Hematologic/Lymph

Anemia

Bleeding problems

Other

Integumentary (Skin)

Cancer

Acne

Other

Neurological

Migraines

Vertigo

Seizures

Tremors

Other

Psychiatric

Anxiety

Depression

Memory loss

Other

Immunologic

Asthma

COPD

Other

Ocular History

What are you being seen for today? ____

Do you wear glasses? YES NO If yes, how old is your present pair of lenses? _________________________

Do you wear Contacts? YES NO If yes, What type? Rigid Soft Toric Multifocal Monovision Extended

Do you wear contacts Full Time Part Time How frequently do you replace them? ___________

Have you had refractive surgery? YES NO If yes, Date _____/_____/______ Type: ________________

What other services would you like to be evaluated for? Refractive Surgery Contact Lens Glasses

Are you currently experiencing any of the following problems with your eyes? Please Circle

Blurred Vision (distance)	Blurred Vision (near)	Flashes
Floaters	Redness	Loss of Vision
Halos/Glare/Light Sensitivity	Excess Tearing/Watering	Loss of Side Vision
Dryness	Eye Pain or Soreness	Distorted Vision
Sandy or Gritty Feeling	Mucous Discharge	Double Vision
Burning	Inflammation of the Eyelid	Tired Eyes
Itching	Sties or Chalazion	

Have you been diagnosed with any of the following ocular problems? Please Circle

Cataracts	Glaucoma	Retinal Detachment/Disease
Crossed Eyes	Lazy Eye/Amblyopia	Dry Eye
Eye Injury	Macular Degeneration	Other: ____________

Glaucoma No Patient Mother Father Sibling Grandparent

Macular Degeneration No Patient Mother Father Sibling Grandparent

Retinal Detachment No Patient Mother Father Sibling Grandparent

Cataracts No Patient Mother Father Sibling Grandparent

Amblyopia/Crossed Eyes No Patient Mother Father Sibling Grandparent

Have you encountered any ocular injuries and or surgeries? YES NO

Please explain ____

Are you prescribed any eye drops, or do you take any over the counter eye drops?

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