Medical History

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

Single Married Divorced Separated Widowed

Full Name: _____

Birthdate: _____/_____/_____

Address: _____

Social Security #: _____-_____-_____

City: _____ ST: _____ ZIP: _____

Home Phone: _____

Email Address: _____

Cell Phone: _____

Occupation: _____

Work Phone: _____

Employer: _____

Parent/ Guardian:_____

Medical Doctor: _____

Last Medical Exam: _____/_____/_____

Previous Eye Doctor:_____

Last Eye Exam:_____/_____/_____

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

Pharmacy_____

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

Diabetes No Patient Mother Father Sibling Grandparent **Year Diagnosed (self) _____ 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 _____

Special Needs Yes No 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

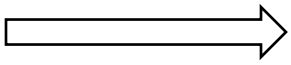
Other

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?

_____

_____