

Medical History

Name: _____ Today's
Date _____ / _____ / _____
Occupation _____ Age _____ Reason for
Visit _____

Medical History

Do you have any allergies to medications? no yes If yes,
explain: _____

List any medication you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

List any of the following you have had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infections, eye injuries, or eye surgeries. _____

Do you wear contact lenses? no yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: Gas Perm Soft/Disposable Other? Are they comfortable? yes no

Family History

Please note any family history or yourself (parents, grandparents, siblings) for the following conditions:

Disease/Condition	No	Yes	Self	Relationship to you
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Review of Systems

Note any of the following problems for yourself:

Eyes

Problem/Condition	No	Yes	Problem/Condition	No	Yes
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>
Mucous/Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Redness	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Infection of Eye/Lid	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>			

Problem/Condition	No	Yes	Problem/Condition	No	Yes
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Anemia/Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to any of the above conditions or have a condition not listed, please explain:

Social History

Do you drive? no yes If yes, do you have any difficulty when driving? no yes

If yes, please describe: _____

Do you use tobacco products? no yes Do you drink alcohol? no yes If yes, how often? _____

Do you use illegal drugs? no yes Wish to speak with doctor, privately.

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

No Change

Date Reviewed _____

Doctor's Signature _____