Medical History Information: ***Please Complete***

NAME (Mr./ Mrs., Ms, Dr) _____ DOB:_____

Reason For Visit:_____ Height:_____ Weight:_____

Primary Health Physician:_____ Last Physical Exam:_____ Last Eye Exam:_____ By Whom:_____

What is your occupation?_____ Hobbies:_____

Ocular Complaints

Blurred Vision	☐YES	☐NO	Cataracts	☐YES	☐NO	Gritty Feeling	☐YES	☐NO
Sudden Vision Loss	☐YES	☐NO	Headaches	☐YES	☐NO	Itching/ Burning	☐YES	☐NO
Loss of Side Vision	☐YES	☐NO	Dry Eye	☐YES	☐NO	Redness	☐YES	☐NO
Double Vision	☐YES	☐NO	Night Glare	☐YES	☐NO	Tearing/ Watery	☐YES	☐NO
Flashes of Light	☐YES	☐NO	Eye Pain	☐YES	☐NO	Poor Night Vision	☐YES	☐NO
Floaters	☐YES	☐NO	Eye Strain	☐YES	☐NO	Sensitivity to light	☐YES	☐NO
						Foreign Body Sensation	☐YES	☐NO

Ocular History			**Which Eye?**		**Ocular History**			**Which Eye?**	
Cataracts Surgery	☐YES	☐NO	R	L	Lasik Surgery	☐YES	☐NO	R	L
Glaucoma	☐YES	☐NO	R	L	Eye Injury	☐YES	☐NO	R	L
Macular Degeneration	☐YES	☐NO	R	L	Lazy Eye	☐YES	☐NO	R	L
Retinal Detachment	☐YES	☐NO	R	L	Other:	☐YES	☐NO	R	L

Medical History

Do you have **DIABETES?** ☐YES ☐NO
How many years?_____
Oral Medication? ☐YES ☐NO
Insulin? ☐YES ☐NO

Do you have **Hypertension?** ☐YES ☐NO Using Medication? ☐YES ☐NO
Do you have **High Cholesterol?** ☐YES ☐NO Using Medication? ☐YES ☐NO
Had a **Stroke** or **Heart Attack/Surgery** in the last year? ☐YES ☐NO
Are you **Pregnant/Nursing?** ☐YES ☐NO

Review Of Systems (please circle):

Constitutional: Fever, Weight loss, Fatigue	☐YES	☐NO	Genitourinary: Genitals, Kidneys, Pregnant	☐YES	☐NO
Ears/Nose/Throat: Allergies, Hearing loss	☐YES	☐NO	Musculoskeletal: Arthritis, Osteoporosis, Gout	☐YES	☐NO
Neurological: Epilepsy, Autism	☐YES	☐NO	Integumentary: Eczema, Rosacea, Psoriasis	☐YES	☐NO
Psychiatric: Depression, Anxiety, Bipolar, ADD	☐YES	☐NO	Endocrine: Thyroid Dysfunction	☐YES	☐NO
Vascular: Hypertension, Heart Disease, Stroke	☐YES	☐NO	Diabetes: Type 1 , Type 2	☐YES	☐NO
Respiratory: Asthma, Emphysema, COPD	☐YES	☐NO	Gastrointestinal: Diarrhea, Constipation	☐YES	☐NO
Digestion: Acid Reflux, Gerd, Crohn's	☐YES	☐NO	Lymphatic/Hematologic: Anemia, High Cholesterol	☐YES	☐NO
Cancer:	☐YES	☐NO			

Medications: (Please list any and all Medication including Over the Counter, Supplements, or Birth Control):

_____ _____
_____ _____
_____ _____
_____ _____

Are you **ALLERGIC** to Medications? ☐YES ☐NO List:_____
Any other **ALLERGIES?:** (Bee Stings, Latex, Food) ☐YES ☐NO List:_____

Family Ocular & Medical History: Relationship to you:

	Father	Mother	Brother	Sister	Son	Daughter
Cancer:	☐	☐	☐	☐	☐	☐
Diabetes:	☐	☐	☐	☐	☐	☐
High Blood Pressure:	☐	☐	☐	☐	☐	☐
Heart Disease:	☐	☐	☐	☐	☐	☐
Thyroid Disease:	☐	☐	☐	☐	☐	☐
Cataracts:	☐	☐	☐	☐	☐	☐
Macular Degeneration:	☐	☐	☐	☐	☐	☐
Glaucoma:	☐	☐	☐	☐	☐	☐

Social: (*ALL information is strictly confidential*)
Use of tobacco products? ☐YES ☐NO
Quantity:_____
Use of alcohol product? ☐YES ☐NO
Quantity:_____
Have you been diagnosed/exposed to any Infectious Disease (HIV,TB,MRSA)? ☐YES ☐NO
Explain: _____
Hepatitis?:_____ Active?: ☐YES ☐NO

Signature: _____ Date:_____