

Patient Medical History

Name: _____ Date: _____ Age: _____

Birth Date: _____ Last eye exam: ____/____ Last Medical Exam: ____/____

Have you had any **EYE** Surgeries? **No** **Yes** please check:

- LASIK CATARACT EYE TURN RK GLAUCOMA
 LASER FOR DIABETES OTHER: _____

Which eye was this on? Right eye Left eye Both eyes

Please check any conditions that apply to YOU:

Ocular History	Right	Left	Ocular History	Right	Left
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Distorted/Halos	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Side vision Loss	<input type="checkbox"/>	<input type="checkbox"/>
Keratoconus	<input type="checkbox"/>	<input type="checkbox"/>	Double vision	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>
Eye Turn	<input type="checkbox"/>	<input type="checkbox"/>	Sandy feeling	<input type="checkbox"/>	<input type="checkbox"/>
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	Eyes Itch	<input type="checkbox"/>	<input type="checkbox"/>
Eye Infection w/ loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Recurring eye infections	<input type="checkbox"/>	<input type="checkbox"/>	Redness	<input type="checkbox"/>	<input type="checkbox"/>
Drooping eyelids	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>
Floater in vision	<input type="checkbox"/>	<input type="checkbox"/>	Foreign body sensation	<input type="checkbox"/>	<input type="checkbox"/>
Tired eyes	<input type="checkbox"/>	<input type="checkbox"/>	Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Vision loss	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain	<input type="checkbox"/>	<input type="checkbox"/>
Vision Blurred	<input type="checkbox"/>	<input type="checkbox"/>	Sties/Chalazion	<input type="checkbox"/>	<input type="checkbox"/>

Medical History	Yes	No	Medical History	Yes	No
Pregnant or nursing	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>			

Please List any Medications you are currently taking: _____

Do you have any **Allergies to medications**? **No** **Yes**, please list: _____

Patient Signature: _____ **Date:** _____

Family History

Please check any family history of the following conditions. If family history is unknown please check here

	Father	Mother	Sibling	Grandparent
Blindness	_____	_____	_____	_____
Cataract	_____	_____	_____	_____
Crossed Eyes	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____
Macular Degeneration	_____	_____	_____	_____
Retinal Detachment Disease	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____
Lupus	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____

Do you drive? No Yes Do you have difficulty when driving? No Yes

Explain: _____

Tobacco? No Yes, Quantity? _____ How Long? _____

Alcohol? No Yes, Quantity? _____ How Long? _____

Review of Systems (About you only)

CONSTITUTIONAL **YES NO**

Weight Loss

Weight gain

EAR/NOSE/MOUTH **YES NO**

Coughing

Stuffy Nose

Hay Fever

Sinus Congestion

Dry Mouth

CARDIOVASCULAR **YES NO**

Heart Disease

High cholesterol

Murmur

Stent

RESPIRATORY **YES NO**

Asthma

Chronic Bronchitis

Emphysema

Lung cancer

Tuberculosis

GASTROINTESTINAL **YES NO**

Diarrhea

Constipation

GENITOURINARY **YES NO**

Kidney stones

STD

MUSCULOSKETAL **YES NO**

Rheumatoid Arthritis

Muscle Pain

Joint Pain

INTEGUMENTARY **YES NO**

Eczema

Psoriasis

NEUROLOGICAL **YES NO**

Dizziness/Vertigo

Fainting

Seizures

Migraines

Numbness

Paralysis

Tremor

PSYCHIATRIC **YES NO**

Memory loss

Depression

Dementia

Nervousness

HEMATOLOGICAL **YES NO**

Anemia

Bleeding problems

Leukemia

Other: _____

Computer usage?

Hours per day? _____

Contact Lenses

Do you wear **YES NO**

Contacts:

What brand do you wear now?

Do you like them? _____

What is your contact lens

prescription? Unknown

Right: _____ Left: _____