MEDICAL HISTORY

Name:____ Today's Date:______________________
Address:____ Phone (h):__________________________
City:_________________ State________ Zip:___________ Phone (c):__________________________
Guardian (if applicable):____________________________ Email:_____________________________
Birth Date: _____/____/______ SS#:_____/____/______ Last Eye Exam: _____/____/________
Occupation:____ Last Med Exam: _____/____/______
Name of Medical Doctor:____________________________ Dr's Phone:______________________

REVIEW OF SYSTEMS

Constitutional	**Yes**	**No**	**?**	**Ears, Nose, Mouth, Throat**	**Yes**	**No**	**?**
Fever, Weight Gain/Loss				Allergies/Hayfever			
Integumentary (skin)				Sinus Congestion			
Neurological				Runny Nose			
Headaches				Post-Nasal Drip			
Migraines				Chronic Cough			
Seizures				Dry Throat / Mouth			
Eyes				**Respiratory**			
Loss of Vision				Asthma			
Blurred Vision				Chronic Bronchitis			
Distorted Vision/Halos				Emphysema			
Loss of Side Vision				**Vascular / Cardiovascular**			
Double Vision				Diabetes			
Dryness				Heart Pain			
Mucous Discharge				High Blood Pressure			
Redness				Vascular Disease			
Sandy / Gritty Feeling				High Cholesterol			
Itching				**Gastrointestinal**			
Burning				Diarrhea			
Foreign Body Sensation				Constipation			
Excess Tearing/Watering				**Genitourinary**			
Glare/Light Sensitivity				Genitals/Kidney/Bladder			
Eye Pain or Soreness				**Bones / Joints / Muscles**			
Chronic Infection of Eye/Lid				Rheumatoid Arthritis			
Sties or Chalazion				Muscle Pain			
Flashes/Floaters in Vision				Joint Pain			
Tired Eyes				**Lymphatic / Hematologic**			
Endocrine				Anemia			
Thyroid / Other Glands				Bleeding Problems			
Psychiatric				**Allergic / Immunologic**			

If you answered YES to any of the above, or have a condition not listed, please explain and list any medications:____
____

SOCIAL HISTORY

This information is kept strictly confidential, but you may discuss this portion directly with the doctor if you prefer.

☐ YES, I would prefer to discuss this information directly with the doctor.

Do you use tobacco products ☐ NO ☐ YES If yes, type/amount / how long______________________________

Do you drink alcohol? ☐ NO ☐ YES If yes, type/amount / how long______________________________

Do you use illegal drugs? ☐ NO ☐ YES If yes, type/amount / how long_____________________________

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

MEDICAL HISTORY

Do you have any allergies to medications? ☐ NO ☐ YES
If yes, explain:____

Please list any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):
____
____

Please list all major injuries, surgeries and /or hospitalizations you have had:
____
____

Have you had any of the following? ☐ crossed eyes ☐ lazy eye ☐ drooping eyelid ☐ glaucoma
☐ prominent eyes ☐ retinal disease ☐ cataracts ☐ eye infection ☐ eye injury

Are you pregnant? ☐ NO ☐ YES

Family History

Please note any family history you have for the following conditions. If no one in your family has experienced a disease/condition, please check the NONE box. If you're not sure about a specific disease/condition, please check the UNKNOWN box.

	None	Mother	Brother	Sister	Son	Daughter	Father	Unknown
Blindness								
Cataract								
Crossed Eyes								
Glaucoma								
Macular Degeneration								
Retinal Detachment/Disease								
Arthritis								
Cancer								
Diabetes								
Heart Disease								
High Blood Pressure								
Kidney Disease								
Lupus								
Thyroid Disease								
Other____________________								