Medical History

Name _____ Date of Birth _____

Date of Last Eye Exam _____

Family Physician _____ Physician Phone _____

Do you have visual difficulty when driving? Y / N Is driver's license renewal needed? Y / N

Do you wear contacts? Y / N If yes, how long? _____ Do you wear them overnight? Y / N

Do you currently wear glasses? Y / N If yes, how long have you had them? _____

Do you smoke? Y / N Packs per week _____ Do you drink? Y / N Glasses per week _____

Medications

List any medications you currently take along with dosage and frequency _____

_____

Are You Allergic to any Medications? (please list) _____

Head/Eyes

Have you ever had any of these problems in the past? Do you currently have any of these problems? If yes, **CIRCLE** which ones and provide an explanation below.

Headaches	Migraines	Loss of Vision	Blurred Vision
Distorted Vision (halos)	Loss of Side Vision	Infection of Eye/Lid	Double Vision
Dryness	Mucous Discharge	Redness	Tired Eye
Sandy/Gritty Feeling	Itching/Burning	Tearing/Watering	Styes, Chalazion
Eye Injury	Foreign Body Sensation	Eye Pain/Soreness	Light Sensitivity
Night Vision Impairment	Problems with Glare	Cataracts	Retinal Disease
Crossed Eyes	Iritis	Corneal Disease	Glaucoma

Fluctuating Visual Acuity Other _____

Explanation _____

_____

_____

(Please continue on other side)

Health History

Have you ever had any of these problems in the past? Do you currently have any of these problems? If yes, **CIRCLE** which ones and provide an explanation below.

Seasonal Allergies	Sinus Congestion	Runny Nose	Post-nasal Drip
Chronic Cough	Dry Throat/Mouth	Lung Disease	Kidney Disease
Arthritis	Diabetes	Neurological Disease	Migraines
Psychiatric Disorder	HIV/AIDS	Heart Disease/Angina	Stroke
Stomach/Intestines	Head or Spinal Injuries	Seizures/Fainting	Asthma
Temporal Areritis	Shortness of Breath	Arthritis/Prosthesis	Prostate/Bladder
TB/Bronchitis	Stroke/Seizures	High Blood Pressure	Thyroid/Lupus
Pregnant or Nursing	Extensive Confinement from Illness or Injury		

Permanent Defect from Illness, Disease or Injury Other _____

Explanation _____

_____

Surgical History

Please include date and type of any previous surgeries. _____

_____

Family History

Please **CIRCLE** if any of your immediate family has been diagnosed with any of the following:

Note Relationship to Yourself: **F** = Father **M** = Mother **P** = Paternal (father's side) **M** = Maternal (mother's side) **S** = Sister **B** = Brother **GF** = Grandfather **GM** = Grandmother **U** = Uncle **A** = Aunt

Blindness _____ Cataracts _____ Macular Degeneration _____

Glaucoma _____ Retinal Detachment _____ Diabetic Retinopathy _____

Diabetes _____ Stroke _____ Heart Condition _____

Other _____

For Office Use Only:

Physician's Signature: _____ Date: _____