

Medical History

Name: _____ Date: _____
 Email: _____ Birth Date: _____
 Last Eye Exam (date): _____ Last Eye Doctor (name): _____
 Last Medical Exam (date): _____ Last Medical Doctor (name): _____

What is your eye problem/complaint today? *Please describe this problem you are having as best as you can.*

Patient Ocular/Medical History	Yes	No
Glaucoma		
Cataracts		
Macular Degeneration		
Eye Injury		
Retinal Disease		
Loss of Vision/Blindness		
Eye Turn/Strabismus		
Lazy Eye/Amblyopia		
Eye Infection		
Dry Eye		
High Blood Pressure/Hypertension		
Diabetes		
Other Disease(s)/Prematurity		
Do you wear glasses?		
Do you wear contact lenses?		
<i>If NO, would you like to?</i>		
Have you ever had a surgery on your eyes?		

If YES, what was it? Why did you have it performed?

Family Ocular/Medical History	Yes	No
Glaucoma		
Cataracts		
Macular Degeneration		
Eye Injury		
Retinal Disease		
Loss of Vision/Blindness		
Eye Turn/Strabismus		
Lazy Eye/Amblyopia		
Eye Infection		
Dry Eye		
High Blood Pressure/Hypertension		
Diabetes		
Other Disease(s)/Prematurity		

What is your preferred pharmacy? _____ Phone Number: _____

Do you have any allergies to medications? _____

Do you have environmental allergies? _____

Social History	Yes	No
Do you smoke?		
<i>If YES, do you smoke every day?</i>		
<i>If NO, did you used to smoke?</i>		
Do you use recreational drugs		
Do you drink alcohol?		
Are you currently pregnant or nursing?		
What is your occupation?		
What are your hobbies?		
How many hours a day do you use a computer?		
What is your current height?		
What is your current weight?		

Patient Review of Health	Yes	No
<i>Do you currently have or ever had problems in the following areas?</i>		
Constitution (Fever, Weight Gain/Loss)		
Cardiovascular/Vascular (Diabetes, High Blood Pressure, Stroke)		
Ears, Nose, Throat, Mouth (Allergies, Sinus Congestion, Dryness)		
Respiratory (Asthma, Bronchitis, Emphysema)		
Gastrointestinal (Diarrhea, Constipation)		
Genitourinary (Genitals, Kidney, Bladder Problems)		
Musculoskeletal (Arthritis, Joint/Muscle Pain)		
Integumentary (Skin Problems)		
Neurological (Headaches, Migraines, Seizures)		
Psychiatric (Mental/Emotional Problems)		
Endocrine (Thyroid/Other Gland Problem)		
Hematologic/Lymphatic (Anemia, Bleeding Problems)		
Allergic/Immunologic (Allergy)		

Medications

List all medications that you currently take (including over-the-counter, vitamins, supplements, oral contraceptives, etc.)

