Medical History

Date:________________

Do you have any allergies to medication? ☐ No ☐ Yes If yes, please list

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List all the medications you take (including oral contraceptives, aspirin, over the counter meds and home remedies).

List major injuries, surgeries, and/or hospitalizations you have had:

List any of the following that you have had: cross eyes, lazy eyes, drooping of eyelid, eye infection, eye injury, eye surgery, glaucoma, cataracts, or macular degeneration?

Do you or have you ever experienced any problems in the following areas?

System	NO	YES
Constitutional		
Fever/Weight loss/ Gain	N	Y
Integumentary		
Eczema	N	Y
Psoriasis	N	Y
Cancer	N	Y
Neurological		
Headaches	N	Y
Migraines	N	Y
Seizures	N	Y
Multiple Sclerosis	N	Y
Ear/Nose/Throat		
Allergies/Hay Fever	N	Y
Sinus Congestion	N	Y
Chronic Cough	N	Y
Dry throat/Mouth	N	Y
Endocrine		
Non-Insulin Dependent Diabetes	N	Y
Insulin Dependent Diabetes	N	Y
Thyroid Disease	N	Y
Hormonal Dysfunction	N	Y
Respiratory		
Asthma	N	Y
Chronic Bronchitis	N	Y
Emphysema	N	Y
Cancer	N	Y
Vascular/Cardiovascular		
High Blood Pressure	N	Y
High Cholesterol	N	Y
Stroke	N	Y
Heart Disease	N	Y
Lymphatic/Hematological		
Bleeding Problems	N	Y
Gastrointestinal		
Chron's	N	Y
Colitis	N	Y
Ulcer	N	Y
Digestive	N	Y
Genitourinary		
Genitals/Kidney	N	Y
Bladder	N	Y
Allergy/Immunological		
Drug Allergy	N	Y
Environmental Allergy	N	Y
Rheumatoid Arthritis	N	Y
Lupus	N	Y
Psychiatric (Depression, Anxiety)	N	Y
Pregnant/Nursing	N	Y

Your Eye Symptoms – Do you (patient) experience any of the following?

Symptom	N	Y
Blurred Vision	N	Y
Distorted Vision	N	Y
Double Vision	N	Y
Red Eyes	N	Y
Watery Eyes	N	Y
Itchy Eyes	N	Y
Burning Eyes	N	y
Dry Eyes	N	Y
Flashing Lights	N	Y
Painful Eyes	N	Y
Gritty/Sandy Eyes	N	y
Aching Eyes	N	Y
Drawing/Pulling	N	Y
Dizziness	N	Y
Excessive Squinting	N	Y
Other___________________________________		
Seeing Rings around Lights	N	Y
Color Vision Difficulties	N	Y
Depth Perception Problem	N	Y
Losing Place while Reading	N	Y
Night Vision Problems	N	Y
Extreme Light Sensitivity	N	Y
Discharge from Eyes	N	Y
Floating Spots	N	Y

Family History – Has anyone in the patient's family (blood relative) had any of the following?

Condition	N	Y
Cataracts	N	Y
Cornea Disease	N	Y
Crossed Eyes	N	Y
Retina Disease	N	Y
Glaucoma	N	Y
Lazy Eye	N	Y
Macular Degeneration	N	Y
Cancer	N	Y
Heart Disease	N	Y
Diabetes	N	Y
High Blood Pressure	N	Y
Other____________________________		

Social History *This information is kept strictly confidential. However, you may discuss this portion directly with your doctor if you prefer.*

☐ Yes, I would prefer to discuss my Social History Information directly with my doctor.

Occupation:____

Do you drive? N Y If yes, do you have visual difficulty when driving N Y

If yes, please describe____

Do you use tobacco products? N Y If yes, type/amount/how long?_________________________

Do you drink alcohol? N Y If yes, type/amount/how long?_________________________

Do you use illegal drugs N Y If yes, type/amount/how long?_________________________

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

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Hobbies/Recreation/Sport – Please mark the boxes that most accurately apply to you.

☐ Boating/fishing ☐ Gardening ☐ Photography ☐ Sewing ☐ Card Playing ☐ Golf ☐ Racquetball ☐ Swimming ☐ Crafts ☐ Hunting ☐ Skiing ☐ Music

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Do you wear glasses? ☐ No ☐ Yes

Do you wear contact lenses? ☐ No ☐ Yes Type of contact lenses: ☐ Rigid ☐ Soft Are they comfortable? ☐ No ☐ Yes

What Brand of contacts do you wear?________________________________ How often do you replace the contacts? Daily 1-2 weeks Monthly Yearly