Medical History

Patient Name____ Date ________________

To provide the best level of eye care, it is necessary to document your complete health history.

Chief complaint/Reason for visit:

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Constitutional
- ❑ Developmental disabilities
- ❑ Cancer ______________
- ❑ Fatigue syndrome

Ear, Nose and Throat
- ❑ Sinusitis
- ❑ Hearing loss
- ❑ Dry mouth
- ❑ Laryngitis

Neurological
- ❑ Stroke
- ❑ Migraines
- ❑ Cerebral palsy
- ❑ Tumor
- ❑ Multiple sclerosis
- ❑ Epilepsy

Psychological
- ❑ Attention deficit disorder
- ❑ Anxiety disorder
- ❑ Depression
- ❑ Bipolar disorder

Cardiovascular
- ❑ Vascular disease
- ❑ Heart disease
- ❑ Congestive heart failure
- ❑ Stroke
- ❑ Hypertension/high blood pressure

Respiratory
- ❑ Cigarette Smoker
- ❑ Sleep apnea
- ❑ Chronic obstruction
- ❑ Emphysema
- ❑ Bronchitis
- ❑ Asthma

Gastrointestinal
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Ulcer
- ❑ Acid reflux
- ❑ Celiac disease

Genitourinary
- ❑ Pregnant
- ❑ Benign prostate hypertrophy
- ❑ Herpes
- ❑ Nursing
- ❑ Chlamydia
- ❑ Kidney disease
- ❑ Prostate disease/cancer

Muscular/Skeletal
- ❑ Fibromyalgia
- ❑ Muscular dystrophy
- ❑ Ankylosing spondylitis
- ❑ Osteoporosis
- ❑ Gout
- ❑ Arthritis
- ❑ Osteoarthritis

Integumentary
- ❑ Eczema
- ❑ Rosacea
- ❑ Herpes zoster/Shingles
- ❑ Psoriasis
- ❑ Herpes simplex/Cold sores

Endocrine
- ❑ Thyroid dysfunction
- ❑ Hormonal dysfunction
- ❑ Type 1 Diabetes Mellitus
- ❑ Type 2 Diabetes Mellitus

Hematological/Lymphatic
- ❑ Anemia
- ❑ Ulcer
- ❑ Large-volume blood loss
- ❑ High cholesterol

Allergic/Immunologic
- ❑ Sjogren's
- ❑ Lupus
- ❑ Rheumatoid arthritis
- ❑ Environmental Allergies
- ❑ Drug allergies

Previous eye surgeries:

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Other surgeries:

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Please list any medications you are currently taking:

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Eye medications or drops:

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Medication Allergies:

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OVER PLEASE

Other Allergies:

- ❑ Bee Stings
- ❑ Enviromental

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- ❑ Food

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Previously Diagnosed Ocular History

- ❑ Inflammatory disorder
- ❑ Strabismus
- ❑ Patching
- ❑ Retinal degeneration
- ❑ Retinal hole
- ❑ Amblyopia
- ❑ Dry Eye
- ❑ Nystagmus
- ❑ Retinal detachment
- ❑ Keratoconus
- ❑ Injury
- ❑ Age-related macular degeneration
- ❑ Cataract
- ❑ Glaucoma suspect
- ❑ Glaucoma

Current Ocular Symptoms

- ❑ Blurred vision at distance
- ❑ Blurred vision at near
- ❑ Distorted vision (halos)
- ❑ Double vision
- ❑ Floaters or spots
- ❑ Fluctuating vision
- ❑ Loss of vision
- ❑ Loss of side vision
- ❑ Headaches
- ❑ Glare/Light sensitivity
- ❑ Tired eyes
- ❑ Amblyopia (lazy eyes)
- ❑ Burning
- ❑ Dryness
- ❑ Excessive tearing/watering
- ❑ Eye pain or soreness
- ❑ Foreign body sensation
- ❑ Infection of eye or lid
- ❑ Itching
- ❑ Mucus discharge
- ❑ Drooping eyelids
- ❑ Redness
- ❑ Sandy or gritty feeling
- ❑ Crossed eyes
- ❑ Problems with night vision
- ❑ Glare problems
- ❑ Visual difficulty while driving

Family Medical History

- ❑ High blood pressure
- ❑ Diabetes
- ❑ Cancer
- ❑ Arthritis
- ❑ Heart disease
- ❑ Kidney disease
- ❑ Lupus
- ❑ Stroke
- ❑ Thyroid disease

Family Ocular History

- ❑ Severe myopia
- ❑ Amblyopia
- ❑ Macular degeneration
- ❑ Glaucoma
- ❑ Dry Eye
- ❑ Retinal Detachment
- ❑ Strabismus
- ❑ Severe hyperopia
- ❑ Nystagmus
- ❑ Cataract

Do you currently wear glasses?

- ❑ No
- ❑ Single Vision
- ❑ Bifocals
- ❑ Trifocals
- ❑ Progressives
- ❑ Safety glasses
- ❑ Sports goggles
- ❑ Prescription sunglasses
- ❑ Had trouble in the past adjusting to bifocals or progressives

Do you currently wear contact lenses?

- Type of lenses:
- Since:
- Hours per day:
- Days per week:
- Solutions:
- Replacement:

Do you currently drink alcohol?

- ❑ No
- ❑ Yes
  - ❑ Amount: ____________

Do you use tobacco products?

- ❑ Never a smoker
- ❑ Former smoker
- ❑ Smoke some days
- ❑ Smoke every day
- ❑ Amount: ____________
- ❑ Cigarettes
- ❑ Cigars
- ❑ Pipe
- ❑ Other

When was your last eye exam?

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Which eye doctor or office did you see?

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Who is your primary care physician?

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When was your last medical check-up?

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Height: ________ **Weight:** _________

Computer Use

- ❑ Hours per day ______
- ❑ Distance from computer ______