Medical History

Patient Name: ________________________ Date of birth: ___________ Today's date: ________________

Primary Care Physician ____

List any medications you take: ____

____

List any allergies to medications: ____

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

____

____

Social History

Do you currently smoke: Y N Do you use smokeless tobacco: Y N

Have you ever smoked: Y N Quantity and for how long: ________________________

Do you drink: Y N Quantity and for how long: ____

Do you use illegal drugs: Y N

Type, Quantity, and for how long: ____

Have you been exposed or infected with: Gonorrhea Hepatitis HIV Syphilis **None**

Review of Systems

Please check any areas that you currently or have ever had problems out of the ordinary

Eyes

- Crossed Eyes/ Lazy eye
- Drooping eyelid
- Loss of Vision/ Loss of Side Vision
- Distorted Vision/ Halos
- Glare/ Light Sensitivity
- Double Vision
- Dryness/ Itching/ Burning
- Sandy or Gritty Feeling
- Excess Tearing/ Watering
- Retinal disease
- Glaucoma
- Cataracts
- Chronic Infection of Eye or Lid
- Sties
- Flashes/ Floater in Vision
- Tired Eyes
- Night Vision/ Driving Problems
- Computer Vision Problems
- Reading/ Distance Vision

Ears, Nose, Mouth, Throat

- Allergies/ Hay fever
- Sinus Problems
- Ear Infections
- Chronic Cough
- Dry Throat/ Mouth

Respiratory

- Asthma
- Breathing Problems
- Chronic Bronchitis
- Emphysema

Vascular/cardiovascular

- Heart Disease
- Heart pain
- High Blood Pressure

Vascular Disease

Neurological

- Headaches
- Migraines
- Seizures

Endocrine

- Thyroid /Other glands
- Diabetes

Genitourinary

- Genitals
- Kidney/Bladder
- Pregnant/ nursing

Psychiatric

Immune System/ Cancer

Lymphatic/ Hematologic

- Anemia
- Bleeding Problems

Bones, Joints, Hematologic

- Rheumatoid Arthritis
- Muscle Pain
- Joint Pain

Integumentary (Skin)

Constitutional

- Fever
- Weight Loss/Gain

Family History

Please note any family history (mother, father, maternal/paternal grandparents, siblings, children, living or deceased)

If yes, put the relationship. If no, leave blank

	If yes, list relationship to you		If yes, list relationship to you
Lazy eye	____________________	Diabetes	____________________
Blindness	____________________	Cancer	____________________
Crossed Eyes	____________________	Heart Disease	____________________
Glaucoma	____________________	High Blood Pressure	____________________
Macular Degeneration	____________________	Immune Deficiencies	____________________
Retinal detachment/Disease	____________________	Lupus	____________________
Thyroid Disease	____________________	Other____________	____________________