

**MEDICAL HISTORY (Please Fill Out)**

Name \_\_\_\_\_ **ALLERGIES (include tape, latex, soap, etc)** \_\_\_\_\_  
Referred by: \_\_\_\_\_  
When was your last eye exam? \_\_\_\_\_  
Optometrist? \_\_\_\_\_ Primary Care Physician \_\_\_\_\_  
Last exam (approximately) \_\_\_\_\_

**Past Medical History** e.g. = examples given

1. Have you ever had any eye surgery, laser, injury or disease? (e.g. cataract, glaucoma, macular degeneration, eye turning in or out, "lazy eye", keratoconus, corneal dystrophy, Grave's Disease)  Yes  No \_\_\_\_\_  
**If yes, explain:** \_\_\_\_\_

2. Do you use any eye drops or eye vitamins?  Yes  No **If yes, please list:** \_\_\_\_\_

3. **EYES (Please circle if you are having any of these symptoms):** Blurred vision, Distorted Vision, Halos, Loss of Side Vision, Double Vision, Flashes of Light, Floaters, Dryness, Mucous Discharge, Redness, Itching, Burning, Watery, Light Sensitivity, Pain/soreness, Fluctuating Vision, **Other:** \_\_\_\_\_

4. Do you take any medications? **Please include aspirin, vitamins, and herbs.**  Yes  No \_\_\_\_\_  
**If yes, please list:** \_\_\_\_\_

**Review of Systems** e.g. = examples given

Do you **currently or have you ever had** any problems with the following?

	Yes	No	If yes, please explain
• Endocrine (e.g. diabetes, thyroid, weight gain or loss).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Ear/nose/throat (e.g. hearing loss, sore throat, sinus).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Heart (e.g. high or low blood pressure, heart problems).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Respiratory(e.g. asthma, short of breath, emphysema, COPD)	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Gastrointestinal (e.g. ulcers, acid reflux, Hiatal hernia).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Urinary/Liver (e.g. kidney problems, cirrhosis, jaundice).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Skin conditions (e.g. rash, excessive dryness).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Musculoskeletal (e.g. rheumatoid arthritis, gout, Lupus, MS)..	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Neurological (e.g. strokes, headaches, Parkinson, Alzheimer)..	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Psychiatric (e.g. depression, anxiety, bipolar, dementia).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Diagnosed with Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>	Type of Hepatitis _____
• Prior Blood Transfusions.....	<input type="checkbox"/>	<input type="checkbox"/>	When? _____
• Diagnosed with cancer and if yes, are you being treated now?	<input type="checkbox"/>	<input type="checkbox"/>	_____
*** If so, are you being treated by hospice	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Family and Social History** e.g. = examples given

1. Do any eye or medical diseases run in your family? (e.g. glaucoma, macular degeneration, keratoconus, retinal detachments, diabetes, high blood pressure, auto immune disorder, cancer)  Yes  No **If yes, please explain:** \_\_\_\_\_  
2. Do you smoke?  Yes  No How much? \_\_\_\_\_ Do you drink alcohol?  Yes  No How much? \_\_\_\_\_

**Physician's Signature** \_\_\_\_\_ **Reviewed by** \_\_\_\_\_