Medical History

Patient Name: _____ Date: _____

Primary Care Doctor: _____ Doctor's Address: _____
(Medical Doctor)

Reason for your visit today: _____ Date of last eye exam: ___/___/_____

Date of Last Medical Exam: ___/___/_____

Are you interested in being fitted (if necessary) for: Glasses Contacts Both

Do you currently wear: Glasses Contacts Both If you currently wear contacts, do you sleep in them? Yes No

*** Please be advised that there is an additional fitting fee for the fitting of contact lenses, which will be charged at each annual exam. ***

Chief Complaint: Please explain any and all difficulties you are experiencing with your vision: _____

Please explain any difficulties you are experiencing with the comfort of your eyes: _____

Computer Usage: Do you use the computer at home or work? ☐ Yes ☐ No Please explain any difficulties: _____

Surgeries: Please list all surgeries you have had: Systemic (body): _____

Eye: _____

Are you interested in Refractive surgery (Lasik)? ☐ Yes ☐ No

Family History of Eye Problems:	None	Yourself	Family member (please list relationship i.e. maternal grandmother)
Blindness:	☐	☐	☐ _____
Eye turn:	☐	☐	☐ _____
Glaucoma:	☐	☐	☐ _____
Macular Degeneration:	☐	☐	☐ _____
Retinal Detachment:	☐	☐	☐ _____
Other: _____	☐	☐	☐ _____

Medications: Please list all : ☐ NONE Systemic: _____

_____

Eye: _____

Please list any medication allergies: ☐ NONE _____

Please list any other allergies: ☐ NONE _____

Social History: Do you use Tobacco? ☐ No ☐ Former ☐ Current, usage: _____

Do you drink Alcohol? ☐ No ☐ Yes: ☐ Social ☐ 1-2 drinks daily ☐ Above average ☐ Other: _____

Non-Prescribed Drug Use: ☐ No ☐ Yes: ☐ Recreational ☐ Other: _____

Review of systems (Please tell us about your medical history) Height: _____ Weight: _____

Allergy	None	Environmental Allergies Food Allergies Animal Allergies	Other:
Cardiovascular	None	High Blood Pressure Heart Disease High Cholesterol Stroke	Other:
Constitutional	None	Appetite problems Sleep problems Fainting Dizziness Fever	Other:
Endocrine	None	Diabetes Type 1 Diabetes Type 2 Crohn's Thyroid Gout	Other:
Gastronintestinal	None	Acid Reflux Colitis Cancer GERD Hepatitis IBS	Other:
Genitourinary	None	Bladder Infection Ovarian tumor Prostate Cancer STD	Other:
Head	None	Encephalitis Headaches Hearing Loss Migraines Meniere's	Other:
Hemotologic/Lymphatic:	None	Anemia Clotting Disorder Leukemia Lymphatic Cancer Sickle Cell	Other:
Immunologic:	None	AIDS Herpes Lyme Disease Reye's Syndrome Sjogren's Sarcoidosis	Other:
Integumentary (Skin):	None	Acne Eczema (Atopic Dermatitis) Lupus Psoriasis Ocular Rosacea	Other:
Musculoskelatal:	None	Arthritis Down's Syndrome Muscular Dystrophy Osteoporosis	Other:
Neurological:	None	Bell's or Cerebral Palsy Epilepsy Parkinson's Seizures Vertigo	Other:
Psychiatric:	None	Anxiety Autism BiPolar Dementia Depression Schizophrenia	Other:
Respiratory:	None	Asthma Bronchitis COPD Emphysemia Lung Disease Turburculosis	Other: