

Last Name _____ First Name _____ Today's Date _____

Date of Birth _____ Date of Last Eye Exam _____ Eye Doctor _____

Date of Last Physical Exam _____ Physician _____

Medical History

List any medications you currently take (prescription and/or over the counter)

Do you have any allergies or allergies to any medications? Yes NO If yes, list the medications:

List all major illnesses (high blood pressure, diabetes, heart attack, glaucoma, etc.) or injuries (concussion, etc.):

List any surgeries and/or hospitalizations you have had (ie. tonsillectomy, appendectomy, cataract)

Are you pregnant and or nursing? Yes [] NO []

Do you wear glasses? Yes [] NO [] If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? Yes [] NO [] If yes, how old is your present pair of lenses? _____

Type of contact lenses? [] Ridgid [] Soft [] Extended Wear [] Other _____ Are they comfortable? [] Yes [] NO

What type of disinfection system do you use? _____

Review of Systems

Do you currently have any problems in the following areas? If "yes", please provide information.

YES NO

	YES	NO
EYES (glaucoma, cataracts, retinal disease, etc)		
Loss of Vision		
Blurred vision		
Fluctuating vision		
Distorted vision (halos)		
Loss of side vision		
Double Vision		
Dryness		
Mucous discharge		
Redness		
Sandy or gritty feeling		
Itching		
Burning		
Foreign body sensation		
Excess tearing/watering		
Glare/light sensitivity		
Eye pain or soreness		
Infection of eye or lid (stye)		
Tired eyes		
Crossed eyes, lazy eye		
Drooping Eyelid		
Flashes/Floaters		
Other		

Review of Systems (continued)

EARS, NOSE MOUTH, THROAT	NO	YES	Explain
Allergies/ Hay Fever	[]	[]	
Sinus congestion	[]	[]	
Runny Nose	[]	[]	
Post-Nasal Dip	[]	[]	
Chronic Cough	[]	[]	
Dry Throat/ Mouth	[]	[]	
RESPIRATORY			
Asthma	[]	[]	
Chronic Bronchitis	[]	[]	
Emphysema	[]	[]	
VASCULAR/ CARDIOVASCULAR			
Diabetes	[]	[]	
Heart Pain	[]	[]	
High Blood Pressure	[]	[]	
Vascular Disease	[]	[]	
GASTROINTESTINAL			
Diarrhea	[]	[]	
Constipation	[]	[]	
GENITOURINARY			
Genitals / Kidney / Bladder	[]	[]	
BONES/ JOINTS/ MUSCLES			
Rheumatoid Arthritis	[]	[]	
Muscle Pain	[]	[]	
Joint Pain	[]	[]	
LYMPHATIC/HEMATOLOGIC			
Anemia	[]	[]	
Bleeding Problems	[]	[]	
ALLERGIC/IMMUNOLOGIC			
PSYCHIATRIC			

Family History (note any family history (parents, grandparents, siblings, children: living or deceased) for the following conditions:	NO	YES	Relationship
Blindness	[]	[]	_____
Cataract	[]	[]	_____
Crossed Eyes	[]	[]	_____
Macular Degeneration	[]	[]	_____
Retinal Detachment	[]	[]	_____
Disease	[]	[]	_____
Arthritis	[]	[]	_____
Cancer	[]	[]	_____
Diabetes	[]	[]	_____
Heart Disease	[]	[]	_____
High Blood Pressure	[]	[]	_____
Kidney Disease	[]	[]	_____
Lupus	[]	[]	_____
Thyroid Disease	[]	[]	_____
Other _____	[]	[]	_____

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

Social History *This information is kept strickly confidential. However, you may discuss this portion directly with the doctor if you prefer.* [] Yes, I would prefer to discuss my Social History information directly with my doctor. (check box)

Do you use tobacco products? [] No [] Yes If yes, type/ amount/ how long: _____

Do you drink alcohol? [] No [] Yes If yes, type / amount/ how long: _____

Do you use illegal drugs? [] No [] Yes If yes, type / amount/ how long: _____

Have you ever been exposed to or infected with: [] Gonorrhea [] Hepatitis [] HIV [] Syphilis

Current occupation / School / Grade ? _____

Marital Status: [] single, [] married, [] widowed, [] divorce

Living arrangements: (asked to determine if assistance is needed for the visually disabled) _____

Doctor _____ Date _____