MEDICAL HISTORY

YOUR NAME: TODAY'S DATE:

CHIEF COMPLAINT-WHY ARE YOU HERE TODAY?

List all eye health problems/symptoms: _____

PAST, FAMILY AND/OR SOCIAL HISTORY - Please answer the following. Please write N/A if it does not apply.

Personal Medical History:

Have you had any major illnesses, injuries, or operations? ☐ YES ☐ NO Explain: _____

Are you taking any medications (Prescriptions and over-the-counter)? ☐ YES ☐ NO List: _____

Do you have any allergies to any medications? ☐ YES ☐ NO List: _____

For women: Are you pregnant/nursing? ☐ YES ☐ NO

Date of Last Medical Exam: _____ Doctor: _____

Family Health History: Please circle any condition in your **family history** and indicate relative affected. (i.e Mother, Father, Maternal Grandparent, Paternal Grandparent, Child, Aunt, Uncle)

High Blood Pressure_____ Glaucoma_____ Blindness_____ Diabetes_____ Stroke _____

Retinal Disease_____ Lazy Eye_____ Cataracts_____ Cancer_____ Tuberculosis _____

Macular degeneration_____ Kidney Disease_____ Heart Disease_____ Arthritis_____ Other_____

Social History:

Your occupation/grade: _____ Place of employment/School: _____

List your sports, hobbies, or special visual needs: _____

How many hours do you use a computer a day? _____

Have you ever been exposed to ? **Herpes** ☐ YES ☐ NO **HIV** ☐ YES ☐ NO **TB** ☐ YES ☐ NO **Hepatitis** ☐ YES ☐ NO

Do you currently use tobacco products ? ☐ YES ☐ NO Have you ever used tobacco products? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO

Do you use recreational drugs? ☐ YES ☐ NO

REVIEW OF SYSTEMS- Check inside boxes if you have a problem with any of the following:

Eyes

Previous Eye Surgery ☐ YES ☐ NO

If so, please explain: _____

_____

_____

_____

_____

_____

_____

Contact Lens	☐ YES ☐ NO
Pain	☐ YES ☐ NO
Double Vision	☐ YES ☐ NO
Glaucoma	☐ YES ☐ NO
Cataracts	☐ YES ☐ NO
Macular Degeneration	☐ YES ☐ NO
Dry Eyes	☐ YES ☐ NO
Flashes	☐ YES ☐ NO
Floaters	☐ YES ☐ NO

→ PLEASE SEE BACK

REVIEW OF SYSTEMS- Check inside boxes if you have a problem with any of the following:

Eyes

- Blurred vision ☐YES ☐NO
- Loss of vision ☐YES ☐NO
- Crossed eyes ☐YES ☐NO
- Watery eyes ☐YES ☐NO
- Red eyes ☐YES ☐NO
- Mucous discharge ☐YES ☐NO
- Burning of itching ☐YES ☐NO
- Sandy or gritty feeling ☐YES ☐NO
- Eye pain or soreness ☐YES ☐NO
- Light sensitivity ☐YES ☐NO
- Chronic eye infections ☐YES ☐NO
- Tired eyes/ Eyestrain ☐YES ☐NO
- Halos/ Glare ☐YES ☐NO
- Retinal detachment ☐YES ☐NO
- Previous vision therapy ☐YES ☐NO
- Previous Eye injury ☐YES ☐NO

Ear/ Nose/ Throat

- Hard of hearing ☐YES ☐NO
- Ringing in ears ☐YES ☐NO
- Vertigo ☐YES ☐NO

Do you have diabetes? ☐YES ☐NO

If you answered YES to diabetes, when were you diagnosed? _____

List your last Blood Sugar? _____

List your last Hemoglobin A1C: _____

Cardiovascular

- Chest pain ☐YES ☐NO
- Dizziness ☐YES ☐NO
- Fainting Spells ☐YES ☐NO
- Shortness of breath ☐YES ☐NO
- Irregular Heart Beat ☐YES ☐NO
- Difficulty Lying Flat ☐YES ☐NO

Constitutional

- Fatigue/Weakness ☐YES ☐NO
- Fever ☐YES ☐NO
- Weight Gain/Loss ☐YES ☐NO

Respiratory

- Cough ☐YES ☐NO
- Congestion ☐YES ☐NO
- Wheezing ☐YES ☐NO
- Asthma ☐YES ☐NO

Gastrointestinal

- Heartburn ☐YES ☐NO
- Nausea/ Vomiting ☐YES ☐NO
- Jaundice/ Hepatitis ☐YES ☐NO

Genitourinary

- Pain/ Difficulty ☐YES ☐NO
- Blood in urine ☐YES ☐NO
- History of Kidney Stones ☐YES ☐NO
- History of STD's ☐YES ☐NO

Psychiatric

- Anxiety/ Depression ☐YES ☐NO
- Mood swings ☐YES ☐NO
- Difficulty Sleeping ☐YES ☐NO

Endocrine

- Increased Thirst ☐YES ☐NO
- Increased Hunger ☐YES ☐NO
- Increased Urination ☐YES ☐NO
- Increased Sweating ☐YES ☐NO
- Fingernail Changes ☐YES ☐NO

Blood/ Lymph Nodes

- Easy bruising ☐YES ☐NO
- Gums bleed Easily ☐YES ☐NO
- Prolonged Bleeding ☐YES ☐NO
- Heavy Aspirin Use

Musculoskeletal

- Stiffness ☐YES ☐NO
- Arthritis ☐YES ☐NO
- Joint Pain/ Swelling ☐YES ☐NO

Skin

- Rashes/ Sores ☐YES ☐NO
- Lesions ☐YES ☐NO
- Hives/ Eczema ☐YES ☐NO

Neurological

- Seizures ☐YES ☐NO
- Weakness/ Paralysis ☐YES ☐NO
- Numbness ☐YES ☐NO
- Tremors ☐YES ☐NO

Immunologic

- Hives ☐YES ☐NO
- Itching ☐YES ☐NO
- Runny Nose ☐YES ☐NO
- Sinus Pressure ☐YES ☐NO

List any other medical conditions not listed above:

_____

_____

_____