Medical History

Are you allergic to any medications? Y/N If yes, explain ____________________

____________________ Are you allergic to Latex? Y/N

List any medications you are taking (including over the counter) ____________________

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Patient Eye History: Do you have any eye problems? Y/N Explain ____________________

Have you had any eye surgery? Y/N Explain ____________________

Do you have:

Cataracts	Y/N	Macular Degeneration	Y/N	Blurred Vision	Y/N	Crossed Eyes	Y/N
Glaucoma	Y/N	Eye Infections	Y/N	Gritty Feeling	Y/N	Prominent Eyes	Y/N
Dry Eyes	Y/N	Retinal Disease	Y/N	Spots in Vision	Y/N	Lazy Eye	Y/N
Red Eyes	Y/N	Drooping Eyelid	Y/N	Tired Eyes	Y/N	Watery Eyes	Y/N
Itching	Y/N	Burning Eyes	Y/N	Double Vision	Y/N	Discharge	Y/N
Styes	Y/N	Flashes in Vision	Y/N	Eye Pain	Y/N	Loss of vision	Y/N

Do you use any eye drops? List ____________________

Do you wear glasses? Y/N Do you wear contacts? Y/N Are you interested in Lasik? Y/N

What is you general health? ____________ Height ________ Weight ____________

For women: Are you pregnant/trying to get pregnant Y/N Taking oral contraceptives Y/N Nursing Y/N

Do you have any problems in the following areas: Please circle yes or no

Integumentary(skin)	Y/N	High Blood Pressure	Y/N	Joint Pain	Y/N	Headaches	Y/N
Allergy	Y/N	Diabetes	Y/N	Osteoporosis	Y/N	Migraines	Y/N
Sinus Congestion	Y/N	Heart Disease	Y/N	BPH	Y/N	Seizures	Y/N
Post Nasal Drip	Y/N	High Cholesterol	Y/N	Menopause	Y/N	Stroke	Y/N
Dry Mouth/Throat	Y/N	Vascular Disease	Y/N	Anemia	Y/N	Ulcers	Y/N
Asthma	Y/N	Acid Reflux	Y/N	Blood Disease	Y/N	Anxiety	Y/N
Chronic Bronchitis	Y/N	Osteoarthritis	Y/N	Thyroid Disease	Y/N	Depression	Y/N
Emphysema	Y/N	Rheumatoid Arthritis	Y/N	Kidney/Bladder	Y/N	HIV Pos.	Y/N
COPD	Y/N	Muscle Pain	Y/N	Cancer ________	Y/N	Other________	

Family History – Members of your family who have the following conditions (M, F, B, S, MGM, MGF, PGM, PGF, A, U)

Blindness______	Macular Degeneration______	Diabetes______	Retinal Disease______
Cataract______	Hypertension______	Cancer______	Retinal Detachment______
Glaucoma______	Heart Disease______	Arthritis______	Other______

Social History – Please circle yes or no

Do you have visual difficulties when you drive? Y/N Explain ____________________

Do you smoke or use tobacco products? Y/N Every Day ____ Some Days ____ If no, have you smoked in past? Y/N

Do you drink alcohol? Y/N Occasional ____ Social ____ Every day ____ How many drinks per day? ______

Do you use a computer? Y/N Hours per day ______ Do you have computer vision problems? Y/N

Demographics

__ White __ Black/African American __ Asian __ American Indian/Alaskan Native __ Native Hawaiian/Pacific Islander

Ethnicity Hispanic or Latino? Y/N **Preferred Language** ____________________

Answering the above questions lets us treat you as a "whole person" and not just a pair of eyes. Many general health conditions may be associated with visual symptoms and eye health issues. A complete medical history is required by our state practice laws and by almost all vision and health care plans. Your indulgence is appreciated.

I have, to the best of my knowledge, answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the optometric office of any changes in medical status.

Signature of Patient, Parent, or Guardian____________________ Date____________