

Primary Care Physician (or name of Clinic) _____ Dr.'s Phone # (____) _____

Please complete the following Medical History for yourself and your family as thoroughly as possible. Many medical conditions may involve the eyes even though it may seem unlikely. Many medications can also have effects on your eyes so please list any and all medications you are currently taking.

Are you pregnant and / or Nursing? No Yes...If yes, how many weeks / months along are you? _____

Date of last Physical: _____ Date of last Eye Exam (here or elsewhere) _____

HEALTH HISTORY:	Self		Family History		Self		Family History		
	Y	N	Relationship to you		Y	N	Relationship to you		
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	_____		High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____		Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____		Elevated Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Ears, Nose, Mouth, Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____		Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____		Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Asthma / Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____		Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____		Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Diabetes Type I	<input type="checkbox"/>	<input type="checkbox"/>	_____		Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Diabetes Type II	<input type="checkbox"/>	<input type="checkbox"/>	_____		Other	<input type="checkbox"/>	<input type="checkbox"/>	_____	
					Urinary Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	_____	

OCULAR HISTORY:	Self		Family History		Self		Family History		
	Y	N	Relationship to you		Y	N	Relationship to you		
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____		Eye Infections	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____		Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____		Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Retinal	<input type="checkbox"/>	<input type="checkbox"/>	_____		Lazy Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Optic Nerve Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____		Drooping Eyelid	<input type="checkbox"/>	<input type="checkbox"/>	_____	
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____		Other	<input type="checkbox"/>	<input type="checkbox"/>	_____	

Medication Allergies: None Penicillin Sulfa drugs Other _____

List any Medications you Currently take (including oral contraceptives, OTC medications, aspirin, and home remedies) None

List all major injuries, surgeries, hospitalizations you have had (approx date) including EYE injuries / surgery: LASIK/PRK, Cataract etc.
 None _____

SOCIAL HISTORY
Please list hobbies you enjoy _____

Do you drink alcohol? No Yes How often? Social use 1-2 drink daily Dependent Other _____

Do you use tobacco product? No Former user Yes How often? Less than 1pk day 1-2pk day More than 2pk / day

Do you use recreational drugs? No Recreational use Chemical dependence Type: _____

Have you ever been exposed to or infected with ?
STD's No Yes _____ Blood Transfusion No Yes

Do you wear glasses? No Yes If yes, how old are your current pairs of glasses? _____

Do you wear contact lenses? No Yes Type of lens: Soft Toric (for astigmatism) Gas Permeable (hard) Multifocal / Monovision

How often do you replace your lenses? Daily 2 weeks Monthly Annual Other _____

Do you sleep in your lenses? No Yes What is the brand of contact lens worn? _____

What solution do you use? Optifree Replenish / Pure Moist BioTrue Renu Other _____

Reason for your visit today?

<input type="checkbox"/> Check eye health	<input type="checkbox"/> Distance Blur	<input type="checkbox"/> Near Blur	<input type="checkbox"/> Computer Blur / Fatigue	<input type="checkbox"/> Night vision blur
<input type="checkbox"/> Headaches	<input type="checkbox"/> Eyestrain	<input type="checkbox"/> Burning	<input type="checkbox"/> Watering	<input type="checkbox"/> Itching
<input type="checkbox"/> Pressure around eyes	<input type="checkbox"/> Dry / Sandy / Gritty feeling	<input type="checkbox"/> Tired eyes	<input type="checkbox"/> Computer Vision fatigue	<input type="checkbox"/> Eye pain
<input type="checkbox"/> Red eyes	<input type="checkbox"/> Flashes / Floaters	<input type="checkbox"/> Double vision	<input type="checkbox"/> Loss of side vision	<input type="checkbox"/> Light sensitivity
<input type="checkbox"/> Other (describe) _____				