MEDICAL HISTORY

Name _____

Primary Care Physician _____

Date of Birth _____ Date of Last Eye Exam _____

Eye Symptoms

	YES	NO		YES	NO		YES	NO		YES	NO
Blurred Vision			Burning			Discharge			Flashes of Light		
Loss of Vision			Tearing			Pain			Floaters/Spots in Vision		
Redness			Itching			Dry Eyes			Glare or Halos around Lights		

Other _____

Review of Systems - Please answer yes or no for each question

	YES	NO		YES	NO		YES	NO
Fever			Chest Pain			Rash		
Fatigue			Irregular Heartbeat			Joint Pain / Swelling		
Dizziness			Abdominal Pain			Muscle Weakness		
Hearing Loss			Nausea / Vomiting			Bleeding/Bruising Easily		
Nasal Congestion			Increased Urination			Depression		
Sore Throat			Increased Thirst			Food Allergies		
Cough			Cold/Heat Intolerance			Environmental Allergies		
Shortness of Breath						Seasonal Allergies		

Please list medications you are currently taking (including eye medications)

Medication Name	Dosage	Medication Name	Dosage

Are you allergic to any medications? ☐ Yes ☐ No _____

Ocular History

	YES	NO		YES	NO		YES	NO		YES	NO
Cataracts			Macular Degeneration			Retinal Detachment			Laser Treatment (LASIK, etc.)		
Glaucoma			Crossed / Lazy Eyes			Injury			Surgery (or other Procedure)		

Eye Surgery / Other Procedures _____

_____

Medical History

	YES	NO		YES	NO		YES	NO		YES	NO
Diabetes ____ yrs			Stroke/Heart Disease			Cancer			Lung Problems		
High Blood Pressure			Migraines			Thyroid			Kidney Disease		
Ear/Nose/Throat/Sinus			Skin Disorders			Arthritis			Immune Disorders		

Surgery / Other Procedures? _____

_____

Family History - Has anyone in your family had any of the following

☐ Cataracts ☐ Macular Degeneration ☐ Glaucoma ☐ Retinal Detachment ☐ Diabetes

Other _____

Social History

Do you smoke? ☐ Yes ☐ No Packs/Day: ___ Years: ___ If No, did you ever smoke? ☐ Yes ☐ No Packs/Day: ___ Year quit: ____

Patient Signature _____ Date _____