MEDICAL HISTORY

Name:_____ Primary Care Physician:_____

Spouse:_____ Child's Parent or Guardian:_____

How did you hear about our office?_____

DO YOU WEAR CONTACTS? Y/N Brand: _____ **GLASSES?** Y/N Updated: _____

WHEN AND WHERE WAS YOUR LAST EYE EXAM?_____

Race: ___White ____American Indian or Alaskan Native ____Asian ___Black or African American

____Native Hawaiian or Other Pacific Islander ____Other Race ____Unknown

Ethnicity: ____Hispanic or Latino ___Not Hispanic or Latino

Current Medications: (Rx and Over the Counter) or present list

Name Dosage Frequency

_____

_____

_____

_____

_____

_____

Allergies (Medical and other):

_____

_____

_____

_____

_____

_____

PERSONAL HISTORY/REVIEW OF SYSTEMS (CHECK ALL THAT APPLY)

EYES
- ☐ Amblyopia
- ☐ Cataract
- ☐ Dry Eye
- ☐ Glaucoma
- ☐ Injury
- ☐ Keratoconus
- ☐ Macular degeneration
- ☐ Nystagmus
- ☐ Patching
- ☐ Retinal degeneration/hole
- ☐ Retinal detachment
- ☐ Strabismus
- ☐ Surgery

CONSTITUTION
- ☐ Cancer
- ☐ Developmental disabilities
- ☐ Fatigue syndrome

NERVOUS SYSTEM
- ☐ Cerebral palsy
- ☐ Epilepsy
- ☐ Migraine/Headache
- ☐ Multiple sclerosis
- ☐ Stroke/CVA
- ☐ Tumor

CARDIOVASCULAR
- ☐ Congestive heart failure
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Vascular disease

RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic Obstruction
- ☐ Emphysema
- ☐ Sleep Apnea

MUSCULO-SKELETAL
- ☐ Ankylosing Spondylitis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Osteoporosis

INTEGUMENTARY (SKIN)
- ☐ Eczema
- ☐ Herpes simplex/cold sore
- ☐ Herpes zoster/shingles
- ☐ Psoriasis
- ☐ Rosacea

ENDOCRINE
- ☐ Hormonal dysfunction
- ☐ Thyroid dysfunction
- ☐ Type 1 diabetes mellitus
- ☐ Type 2 diabetes mellitus

Last A1C_____

OVER

EARS/NOSE/THROAT
☐Dry Mouth
☐Hearing Loss
☐Sinusitis

GASTROINSTESTINAL (GI)
☐Acid reflux
☐Celiac disease
☐Colitis
☐Crohn's disease
☐Ulcer

PSYCHIATRIC
☐Anxiety disorder
☐Attention deficit
☐Bipolar disorder
☐Depression

GENITOURINARY (GU)
☐Benign Prostate hypertrophy
☐Chlamydia
☐Herpes
☐Prostate disease

HEMATOLOGICAL(Blood/Lymph)
☐Anemia
☐High cholesterol
☐Large volume blood loss

ALLERGY/IMMUNOLOGIC
☐Lupus
☐Rheumatoid arthritis
☐Sjogren's syndrome

Are you nursing ? Y/N Are you pregnant? Y/N Due Date:_____

OTHER MEDICAL CONDITIONS:

_____

_____

Do you Drive? Y / N
Do you consume alcohol? Y / N
Do you smoke or vape? **Current / Former / Never**

FAMILY MEDICAL AND OCULAR HISTORY: (CHECK ALL THAT APPLY)

	MOTHER	**FATHER**	**SISTER**	**BROTHER**	**DAUGHTER**	**SON**
DIABETES						
HYPERTENSION						
THYROID						
CANCER						
MACULAR DEGENERATION						
GLAUCOMA						
OTHER						