

MEDICAL HISTORY

Name	Today's Date / /		
Address	City	ST	Zip
Phone Numbers: Home ()	Daytime ()	Birthdate / /	
Referred by:			
Date of last medical exam / /	Date of last eye exam / /		

MEDICAL AND PAST HISTORY

List any medications you take:

List all major illnesses and injuries:

List any surgeries you have had:

Have you had crossed eyes?	Yes	No
Have you had lazy eye?	Yes	No
Have you had drooping eyelid?	Yes	No
Have you had prominent eyes?	Yes	No
Do you have allergies to any medications?	Yes	No

FAMILY HISTORY DISEASE

RELATIONSHIP TO PATIENT

	Yes	No	
Blindness	Yes	No	<hr/>
Cataract	Yes	No	<hr/>
Glaucoma	Yes	No	<hr/>
Macular degeneration	Yes	No	<hr/>
Retinal detachment	Yes	No	<hr/>
Arthritis	Yes	No	<hr/>
Cancer	Yes	No	<hr/>
Diabetes	Yes	No	<hr/>
Heart attacks	Yes	No	<hr/>
High blood pressure	Yes	No	<hr/>
Kidney disease	Yes	No	<hr/>
Lupus	Yes	No	<hr/>
Sjogrens Syndrome	Yes	No	<hr/>
Stroke	Yes	No	<hr/>
Thyroid disease	Yes	No	<hr/>
Tuberculosis	Yes	No	<hr/>
Other	Yes	No	<hr/>

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion only with the doctor if you prefer.

Current Occupation:

Do you drive?	Yes	No
Do you have visual difficulty when driving?	Yes	No

Do you have problems with night driving?	Yes	No
Have you ever tried to wear contacts?	Yes	No
Do you currently wear glasses?	Yes	No
If YES, how long have you had your current pair?		
Do you drink alcohol?	Yes	No
If YES, how many glasses a day?		
Do you smoke?	Yes	No
If YES, how many packs a day?		
Have you ever had a blood transfusion?	Yes	No
Have you ever been exposed to HIV or other STD's?	Yes	No

REVIEW OF SYMPTOMS

Do you currently have any problems in the following areas? If "yes" provide information

Constitutional Symptoms

Fever	Yes	No
Weight loss	Yes	No
Other	Yes	No

Eyes

Loss of vision	Yes	No
Blurred vision	Yes	No
Distorted vision (halos)	Yes	No
Loss of side vision	Yes	No
Double vision	Yes	No
Dryness	Yes	No
Mucous discharge	Yes	No
Redness	Yes	No
Sandy or gritty feeling	Yes	No
Itching	Yes	No
Burning	Yes	No
Foreign body sensation	Yes	No
Excess tearing/watering	Yes	No
Occasional tearing	Yes	No
Glare/Light sensitivity	Yes	No
Eye pain or soreness	Yes	No
Chronic infection of eye or lid	Yes	No
Styes, Chalazion	Yes	No
Fluctuating visual acuity	Yes	No
Tired eyes	Yes	No

Psychiatric

	Yes	No
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Endocrine

Thyroid and other glands	Yes	No
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Hematologic/Lymphatic

Blood	Yes	No
Lymph nodes	Yes	No
Swelling	Yes	No

Ears, Nose, Mouth and throat

Sinus congestion	Yes	No
Runny nose	Yes	No
Postnasal drip	Yes	No
Chronic cough	Yes	No
Dry throat/mouth	Yes	No

Vascular/Cardiovascular

Diabetes	Yes	No
Heart pain	Yes	No
High blood pressure	Yes	No
Vascular Disease	Yes	No

Respiratory (lungs/breathing)

Chronic bronchitis	Yes	No
Asthma	Yes	No
Emphysema	Yes	No

Gastrointestinal (stomach/intestines)

Diarrhea	Yes	No
Constipation	Yes	No

Genitourinary

	Yes	No
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Musculoskeletal

Muscle pain	Yes	No
Joint pain	Yes	No
Rheumatoid Arthritis	Yes	No

Integumentary

	Yes	No
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Neurological

Headaches	Yes	No
Migranes	Yes	No
Seizures	Yes	No

Allergic/Immunologic

Head allergy symptom	Yes	No
Seasonal allergies	Yes	No
Hay fever symptoms	Yes	No

If you answered YES to any of the above or have a condition not listed, please explain and list all medications:

History reviewed. No changes Additions as noted above

Physician's Signature: _____ Date: _____