# 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** | | | **RELATIONSHIP TO PATIENT** |
|---|---|---|---|
| **DISEASE** | | | |
| | Yes | No | _____ |
| Blindness | Yes | No | _____ |
| Cataract | Yes | No | _____ |
| Glaucoma | Yes | No | _____ |
| Macular degeneration | Yes | No | _____ |
| Retinal detachment | Yes | No | _____ |
| Arthritis | Yes | No | _____ |
| Cancer | Yes | No | _____ |
| Diabetes | Yes | No | _____ |
| Heart attacks | Yes | No | _____ |
| High blood pressure | Yes | No | _____ |
| Kidney disease | Yes | No | _____ |
| Lupus | Yes | No | _____ |
| Sjogrens Syndrome | Yes | No | _____ |
| Stroke | Yes | No | _____ |
| Thyroid disease | Yes | No | _____ |
| Tuberculosis | Yes | No | _____ |
| Other | Yes | No | _____ |

**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 |
| **Phsychiatric** | Yes | No |
| **Endocrine** | | |
| Thyroid and other glands | Yes | No |
| **Hematologic/Lymphatic** | Yes | No |
| 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 |
| **Musculoskeletal** | | |
| Muscle pain | Yes | No |
| Joint pain | Yes | No |
| Rheumatoid Arthritis | Yes | No |
| **Integumentary** | Yes | No |
| **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: