MEDICAL AND EYE HEALTH HISTORY

Name_____ Date____/____/____

Birth Date ____/____/____ Last Medical Exam ____/____/____ Last Eye Exam ____/____/____

Name of Medical Doctor_____ City_____

Eye History

Check any of the following that you have had:

☐ crossed eyes ☐ lazy eyes ☐ drooping eyelid ☐ glaucoma
☐ retinal disease ☐ cataracts ☐ eye infections ☐ eye injury

Do you wear glasses? ☐ no ☐ yes If yes, how old is your present pair of lenses?_____
Do you wear contact lenses? ☐ no ☐ yes If yes, how old is your present pair of lenses?_____
Type of contact lenses: ☐ Rigid ☐ Soft ☐ Are they comfortable? ☐ yes ☐ no

Medical History

List all major injuries, surgeries and / or hospitalizations you have had_____

_____

Do you have any allergies to medications? ☐ no ☐ yes If yes,explain_____

_____

List any medications you take (including oral contraceptives, aspirin,over the counter medications and home remedies):_____

_____

Are you pregnant and / or nursing? ☐ no ☐ yes

Family History

Please note any family history (parents, grandparents, siblings and / or children, living or deceased) for the following medical conditions:

	No	Yes	?	Relationship To You
Blindness	___	___	___	_____
Crossed Eyes	___	___	___	_____
Glaucoma	___	___	___	_____
Macular Degeneration	___	___	___	_____
Retinal Detachment / Disease	___	___	___	_____
Arthritis	___	___	___	_____
Cancer	___	___	___	_____
Diabetes	___	___	___	_____
Heart Disease	___	___	___	_____
High Blood Pressure	___	___	___	_____
Kidney Disease	___	___	___	_____
Lupus	___	___	___	_____
Thyroid Disease	___	___	___	_____

Other_____

(please turn this form over and complete side two)

Social History

Do you drive? ☐no ☐yes If yes, do you have visual difficulty when driving? ☐ no ☐ yes

If yes, please describe:_____

Do you drink alcohol? ☐no ☐ yes If yes, amount?_____

Do you use tobacco products? ☐ no ☐ yes If yes, amount / how long?_____

Do you use illegal drugs? ☐ no ☐ yes If yes, type / amount / how long?_____

Have you ever been exposed to or infected with ☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ Hepatitis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

	no	yes	?
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	___	___	___
Muscle Pain	___	___	___
Joint Pain	___	___	___
EARS, NOSE, MOUTH, THROAT			
Allergies	___	___	___
Hay Fever	___	___	___
Sinus Congestion	___	___	___
Runny Nose	___	___	___
Post - Nasal Drip	___	___	___
Chronic Cough	___	___	___
Dry Throat / Mouth	___	___	___
ENDOCRINE			
Thyroid / other gland	___	___	___
EYES			
Loss of Vision	___	___	___
Blurred Vision	___	___	___
Distorted vision / Halos	___	___	___
Loss of Side Vision	___	___	___
Double Vision	___	___	___
Dryness	___	___	___
Mucus Discharge	___	___	___
Redness	___	___	___
Sandy or Gritty Feelings	___	___	___
Itching	___	___	___
Burning	___	___	___
Excess Tearing / Watering	___	___	___
Glare / Light Sensitivity	___	___	___
Eye Pain or Soreness	___	___	___
Infections of Eye or Lid	___	___	___
Sties or Chalazion	___	___	___
Flashes / Floaters	___	___	___
Tired Eyes	___	___	___

	no	yes	?
GASTROINTESTINAL			
Diarrhea	___	___	___
Constipation	___	___	___
GENITOURINARY			
Genitals	___	___	___
Kidneys	___	___	___
Bladder	___	___	___
INTEGUMENTARY			
Skin	___	___	___
LYMPHATIC / HEMATOLOGIC			
Anemia	___	___	___
Bleeding Problems	___	___	___
NEUROLOGIC			
Headaches	___	___	___
Migraine	___	___	___
Seizures	___	___	___
PSYCHIATRIC	___	___	___
RESPIRATORY			
Asthma	___	___	___
Chronic Bronchitis	___	___	___
Emphysema	___	___	___
VASCULAR			
Diabetes	___	___	___
Heart Pain	___	___	___
Hi Blood Pressure	___	___	___
Vascular Disease	___	___	___

_____ _____

Doctor's Signature Review Date