Medical History

Last Eye Exam (date):_____
Last Eye Doctor(name):_____
Primary Care Doctor:_____

What is your eye problem/complaint today?

_____
_____

Please check all that apply

Patient Ocular/Medical History

Glaucoma	
Cataracts	
Macular Degeneration	
Eye Injury	
Retinal Disease	
Loss of Vision/Blindness	
Eye Turn/Strabismus	
Lazy Eye/Amblyopia	
Dry Eye	
High Blood Pressure	
Diabetes	
Other Diseases	
Do you wear glasses?	
Do you wear contacts?	
Have you ever had eye surgery?	

Family History *Any members have:*

Glaucoma	
Cataracts	
Macular Degeneration	
Loss of Vision/Blindness	
Retinal Disease	
Lazy Eye/Amblyopia	
Eye Turn/Strabismus	
Diabetes	
High Blood Pressure	
Other Diseases	

Medications *(If you have a list please provide)*

_____
_____
_____
_____
_____

Medication Allergies

_____
_____

Social History

Do you smoke?	
Do you use recreational Drugs?	
Are you pregnant or nursing?	
Do you work on the computer?	
Do you have outdoor hobbies?	
Are you interested in LASIK?	
Are you interested in contact lenses?	

Patient Review of Health

Do you have problems in the following areas?

Constitution (*Fever, Weight gain/loss)*	
Cardiovascular *(Cholesterol, High Blood Pressure, stroke)*	
Ear, Nose, Throat *(Allergies, Sinus Cong.)*	
Respiratory *(Asthma, Bronchitis, Emphysema)*	
Gastrointestinal *(Diarrhea, Constipation)*	
Genitourinary *(Kidney, Bladder Problems)*	
Musculoskelatal *(Arthritis, Joint/Muscle)*	
Integumentary *(Skin Problems)*	
Neurological *(Headache, Migraines, Seizure)*	
Psychiatric *(Mental, Emotional Problems)*	
Endocrine *(Thyroid, Diabetes)*	
Hematologic/Lymphatic *(Anemia, Bleeding problems)*	
Allergic/Immunologic *(Allergy)*	