

MEDICAL HISTORY

Name _____ Date _____

Date of Birth _____ Date of last eye exam _____

List any **medications** you currently take (Rx and over-the-counter): _____

Do you have **allergies** to any medications? **YES** **NO**

If YES, list the medications: _____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):

List any **surgeries** you have had (cataract, appendectomy): _____

Do you **currently** have any problems in the following areas? If 'YES', please provide additional information.

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, hernia, constipation, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			
HIV			
HEPATITIS			

FAMILY HISTORY

(Mother, Father, Sibling, Grandparent)

Has any member of your family had these diseases (circle all that apply)? **YES** **NO** **UNKNOWN**
 Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
 Other heritable disease: _____

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES** **NO**
 Have you ever had a blood transfusion? **YES** **NO**
 Do you drink alcohol? **YES** **NO** If YES, how much? _____
 Do you smoke? **YES** **NO** If YES, how much? _____ How many years? _____

Physician's Signature _____ Date _____