# MEDICAL HISTORY

Patient's Name: _____ DOB: _____

Email: _____

| *Current Problems* | *Yes* | *No* | *Fam HX* |
|---|---|---|---|
| **Blood/Lymph** (Anemia) | | | |
| **Ear/Nose/Throat** (Sinus, Allergies, Infections, Hearing) | | | |
| **Endocrine** (Diabetes, Thyroid) | | | |
| **Gastrointestinal** (Acid Reflux) | | | |
| **Heart/Cardiovascular** (Hypertension, Cholesterol, Surgery) | | | |
| **Musculoskeletal** (Muscle aches, Arthritis) | | | |
| **Neurological** (Headaches, Stroke, Seizures) | | | |
| **Psychiatric** (ADD, ADHD, Depression, Anxiety) | | | |
| **Respiratory** (COPD, Asthma, Emphysema) | | | |
| **Skin** (Rashes, Eczema, Dryness) | | | |
| **Urinary** (Kidney/Stones, Blood in urine) | | | |
| **Current Smoker?** | | | |
| **Drug & Seasonal Allergies? List:** | | | |
| **Current Medications:** (Include eye drops, vitamins) | | | |

| *Current Symptoms* | *Yes* | *No* | *Fam HX* |
|---|---|---|---|
| Blurred distance vision | | | |
| Blurred intermediate vision | | | |
| Blurred near vision | | | |
| Sudden loss of vision | | | |
| Double vision | | | |
| Eye pain | | | |
| Glare,light sensitivity, or halos | | | |
| Flashes of light and/or floaters | | | |
| Bump on eyelid or droopy eyelid | | | |
| Headaches | | | |
| Discharge (watery, mucus) | | | |
| | | | |
| Itching, burning, stinging | | | |
| Sore/Tired eyes | | | |
| Dryness | | | |
| Excessive tearing/watering | | | |
| Sandy, gritty | | | |
| Redness | | | |
| Foreign body sensation | | | |
| Fluctuating vision | | | |
| Contact lens discomfort | | | |
| Other: | | | |

Height: _____ Weight: _____ Declined ☐

Alcohol use: Yes/No Recreational drug use: Yes/ No

| *Eye Health History* | *Yes* | *No* | *Fam HX* |
|---|---|---|---|
| Cataracts | | | |
| Glaucoma | | | |
| Macular Degeneration | | | |
| Lazy Eye | | | |
| Color Blindness | | | |
| Astigmatism | | | |
| Diabetic Retinopathy | | | |
| Blindness | | | |
| Keratoconus | | | |
| Eye Surgery | | | |

***New Patients Only:***

Previous eye doctor: _____

City: _____

Last Eye Exam: _____

Primary Care Physician _____

Do you have current eyewear? Yes ☐ No ☐

Do you have current contact lenses? Yes ☐ No ☐

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**FOR DRY EYE AND ALLERGY SUFFERERS**:

WHAT TREATMENT OR THERAPY OPTIONS HAVE YOU TRIED TO RELIEVE YOUR SYMPTOMS?

☐ ARTIFICIAL TEARS ☐ PRESCRIPTION EYE DROPS

☐ PUNCTAL PLUGS ☐ ARE THEY TREATABLE?

**To my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.**

**Patient/Guardian Signature: _____ Date _____**

**_____O.D. __/__/__ _____O.D. __/__/__ _____O.D. __/__/__**