

Medical History Form

Name _____ DOB _____ Date _____

Please fill in the following information

1. When was your last complete eye examination? _____ Doctor? _____
2. When was your last complete physical examination? _____ Doctor? _____

Personal Ocular History

Y? N? Lazy eye Y? N? Turned eye Y? N? Dry eyes/Burning eyes Y? N? Eye infections Y? N? Double Vision
Y? N? Glaucoma Y? N? Cataracts Y? N? Macular degeneration Y? N? Keratoconus Y? N? Retinal detachment
Y? N? Flashes/Floaters Y? N? Color Deficiency ? Other _____

1. Have you ever had an eye injury? Y N Type _____ Date _____
2. Eye Surgeries? Y N Type _____ Date _____
3. Do you currently wear glasses? Y N Contact Lenses? Y N What type? Soft _____ Hard _____
4. Main reason for having your eyes examined today: _____

Personal Medical History

Neg ___ <u>Constitutional</u>	Neg ___ <u>Ear, Nose, Mouth, Throat</u>	Neg ___ <u>Respiratory</u>	Neg ___ <u>Musculoskeletal</u>
? Cancer	? Upper respiratory tract infection	? Asthma	? Muscular dystrophy
? Fatigue	? Sinus	? Emphysema	? Osteoarthritis
? Weight loss	Neg ___ <u>Cardiovascular</u>	Neg ___ <u>Genitourinary</u>	Neg ___ <u>Endocrine</u>
? Pregnancy	? Heart disease	? Urinary tract infections	? Non-insulin diabetes
Neg ___ <u>GI</u>	? Hypertension	? Kidney ailments	? Insulin diabetes
? Hepatitis	? Stroke	Neg ___ <u>Psychiatric</u>	? Thyroid dysfunction
Neg ___ <u>Hematology/Lymphatic</u>	Neg ___ <u>Neurological</u>	? Depression	Neg ___ <u>Immunologic</u>
? Anemia	? Multiple Sclerosis		? Rheumatoid arthritis
? Leukemia	? Headaches		? HIV/Aids ? Lupus

Other _____

1. Have you had any surgeries? ?Y ?N Type? _____
2. Do you use cigarettes/tobacco? ?Y ?N Alcohol? ?Y ?N Other Substances? ?Y ?N
3. Date of last Tetanus shot? _____

Medications

Please list ALL medications you are presently taking (including hormones, birth control pills, and supplements) _____ ? N/A

Have you ever had any adverse or allergic reaction to food or medication? If so please describe. _____ ? N/A

Family Ocular Health

Relationship	Relationship
?Y? N Lazy eye _____	?Y? N Macular degeneration _____
?Y? N Turned Eye _____	?Y? N Retinal detachment _____
?Y? N Glaucoma _____	?Y? N Blindness _____
?Y? N Cataracts _____	?Y? N Color blindness _____

Family Medical History

?Y? N Diabetes _____ ?Y? N Heart disease _____
?Y? N High Blood Pressure _____ ?Y? N Migraine _____
?Y? N Stroke _____ ? Other _____

Visual Needs

Which of the following visual demands do you most often have at work?
? Computer ? Reading ? Driving ? Other _____

Do you enjoy any of the following hobbies/recreation?
? Golf ? Tennis ? Reading ? Needlework/sewing ? Fishing
? Shooting ? Other _____

Are you interested in any of the following?
? Contacts ? Corneal molding (CRT) ? Refractive Surgery ? Other _____

Contact Lens Wearers

Are you currently having any discomfort with your current lenses? (explain) _____