Medical History Form

Patient Name: ______________________ Last Physical Exam? ____________ Last Eye Exam? ____________

Primary reason for today's visit (Chief Complaint) : ______________________ Current Vision Problems: ______________

Major Illnesses or injury:	Currently taking medications?	For?	Surgeries?	Eye Drops?

Drug Allergies? Please list drug & reaction:

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Current Eye Symptoms		Review of Symptoms	Family History Eye Diseases Relationship
Glaucoma ❍Yes ❍No	Drooping Eyelid ❍Yes ❍No	Fever ❍Yes ❍No	Amblyopia (Lazy Eye) ❍Yes ❍No
Cataract ❍Yes ❍No	Redness ❍Yes ❍No	Weight Loss ❍Yes ❍No	Blindness ❍Yes ❍No
Macular Degeneration ❍Yes❍No	Sandy or Gritty Feel ❍Yes ❍No	Other Constitutional Prob ❍Yes ❍No	Cataract(s) ❍Yes ❍No
Retinal Detachment ❍Yes ❍No	Crossed Eyes ❍Yes ❍No	Ear, Nose, Throat ❍Yes ❍No	Color Blindness ❍Yes ❍No
Color Blindness ❍Yes ❍No	Blurred Dist Vision ❍Yes ❍No	Cardiovascular ❍Yes ❍No	Glaucoma ❍Yes ❍No
Headaches ❍Yes ❍No	Blurred Near Vision ❍Yes ❍No	Respiratory ❍Yes ❍No	Macular Degeneration ❍Yes ❍No
Glare/Light Sensitive ❍Yes ❍No	Distorted Vision (Halos) ❍Yes❍No	Gastrointestinal ❍Yes ❍No	Retinal Detachment ❍Yes ❍No
Tired Eyes ❍Yes ❍No	Double Vision ❍Yes ❍No	Genital, Kidney, Bladder ❍Yes ❍No	Crossed Eyes ❍Yes ❍No
Amblyopia (Lazy Eye) ❍Yes ❍No	Floaters or Spots ❍Yes ❍No	Muscles, Bones, Joints ❍Yes ❍No	Arthritis ❍Yes ❍No
Burning ❍Yes ❍No	Fluctuation Vision ❍Yes ❍No	Skin Problems ❍Yes ❍No	Cancer ❍Yes ❍No
Dryness ❍Yes ❍No	Loss of Vision ❍Yes ❍No	Neurological ❍Yes ❍No	Diabetes ❍Yes ❍No
Excess Tearing/Watering ❍Yes ❍No	Loss of Side Vision ❍Yes ❍No	Psychiatric Problems ❍Yes ❍No	Heart Disease ❍Yes ❍No
Eye Pain/Soreness ❍Yes ❍No		Endocrine (Diabetes, thyroid, etc.)❍Yes ❍No	High Blood Pressure ❍Yes ❍No
Foreign Body Sensation ❍Yes ❍No		Blood/Lymph (anemia, etc.)❍Yes ❍No	Kidney Disease ❍Yes ❍No
Infection of Eye or Lid ❍Yes ❍No		Allergic/Immunologic ❍Yes ❍No	Lupus ❍Yes ❍No
Itching ❍Yes ❍No		Pregnant / Nursing or both❍Yes ❍No	Stroke ❍Yes ❍No
Mucous Discharge ❍Yes ❍No			Thyroid Disease ❍Yes ❍No
			Other ❍Yes ❍No

Social History

Current Occupation: ______________________ Yrs________ Employer ______________________

Computer Used ? _____ Hrs per day ? _____ Dist from computer ? _______

Do you drive? ❍Yes ❍No How many miles to & from work? __________

Do you have visual difficulty when driving? ❍Yes❍No

Do you have problems with night vision? ❍Yes❍No

Do you have glare problems? ❍Yes❍No

Do you currently wear glasses? ❍Yes❍No

Do you wear sunglasses? ❍Yes❍No Prescription? ❍Yes❍No

Do you engage in regular exercise ? ❍Yes ❍No

Do you smoke? Occasional, ½ pk/day, 1 pk/day, 1+ pk/ day

Do you wear contacts? ❍Yes❍No

If no, have you ever worn them? ❍Yes❍No

Are you interested in contacts today? ❍Yes❍No

How would you rate your current contact lens comfort?

What brand on contacts do you wear ? ______________________

Do you take nutritional supplements (vitamins, etc.) ? ❍Yes ❍No

Do you drink alcohol ? ❍Yes ❍No Occ, 1 per day, 2-3 per day, 4+ per day