Medical History

Name_____________________________________ Today's Date_____________________
Address___________________________________ Date of Birth______________________
____ Occupation________________________
Phone____________________________________ Hobbies__________________________
Name of Primary Medical Doctor____
Last Medical Exam_________________________ Last Eye Exam(with an eye doctor)___________

What is your reason for today's eye exam? Please mark all that apply.

___blur at distance ___red eyes ___eye turn/crossed eyes
___blur at near ___glaucoma ___eye pain/discomfort
___computer strain ___flashes/spots ___itching
___double vision ___headache ___broken glasses
___vision loss ___tears/discharge ___contact lenses/color contact lenses

Have you had an eye injury? __no __yes If yes, explain: ___________________________
Have you had eye surgery? __no __yes If yes, explain: ___________________________
How old are your current glasses? __________________________
What brand contacts do you wear? (If unknown, state whether hard or soft)________________________
How often do you replace your current contact lenses? ___daily ___2 weeks ___monthly ___yearly

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Do you have, or have you ever been treated for:

___diabetes (high sugar) ___arthritis/joint pain ___asthma/sleep apnea
___high blood pressure ___kidney/urinary ___depression/anxiety
___heart disease ___thyroid/glands ___sinus/allergy
___high cholesterol ___STD/HIV ___skin condition
___stomach problems ___cancer ___hearing loss
___stroke ___headache ___other__________________________

Do you take any medications? (including vitamins, birth control, Viagra, etc) ___no ___yes If yes, list:__
____

Do you have any allergies to medication? ___no ___yes If yes, explain: _____________________
Are you pregnant? __no __yes Are you nursing? __no __yes
Do you smoke? __no __former smoker __yes How much? ½ pack/day 1pack/day 2-3 packs/day
Do you drink alcohol? __no __yes How much? social use only 1-2 drinks/day 3+ drinks/day
Do you have a history of recreational drug use? __no __yes

Please list your blood relatives (i.e. father, aunt, etc) who have the following medical problems:

__________diabetes __________high blood pressure __________heart disease
__________arthritis __________sickle cell disease __________retinal disease
__________glaucoma __________macular degeneration __________crossed eyes
__________blindness __________other