MEDICAL HISTORY

Patient Name:_____ **Date of Birth:**_____ **Date of Service:**_____

Reason for today's eye exam: _____

1. Which eye(s) are affected? _____
2. Is the problem mild, moderate, or severe?_____
3. Does anything make the problem worse? _____
4. Does anything make the problem better?_____
5. When approximately did it start?_____
6. How is the vision affected? _____

Please circle all that apply. Do you currently wear: Glasses, over the counter reading glasses, or Contact lens?

Current contact lens brand/ prescription: Right Eye : _____

Left Eye: _____

Please circle all medical conditions you may have: High blood pressure High cholesterol Diabetes Arthritis Blood disorder Asthma COPD Ear/Nose/throat Thyroid Neurological Heart Gastrointestinal Migraines Genitourinary Cancer: active / cured

Please list any prior major surgeries _____

_____

Who is your primary care physician?: _____

Please circle any Eye problems you have had: Glaucoma Cataract trauma Amblyopia /Strabismus Corneal disease Retinal Detachment Macular degeneration Dry Eyes Blindness

Others: _____

Please list prior eye surgeries/lasers and the approximate year:_____

_____

Family Ocular History: (Please circle all that apply) : Glaucoma Cataract trauma Amblyopia/Strabismus Corneal disease Retinal Detachment Macular degeneration Blindness

Other:_____

Review of Systems Please Circle any that apply to your CURRENT status of health:

General /Constitutional : Fatigue or weight change **Skin:** Lesion (s) or rash (es) **Ears:** Hearing loss, ringing

NOSE : sinus problems, nose bleed **Throat:** sore throat **Respiratory:** Shortness of breath, cough

Cardiovascular: Heart trouble, chest pain, or swelling of feet, or ankle(s) **Gastrointestinal:** Loss of appetite or abdominal pain **Neurological:** Headaches or numbness **Endocrine:** Heat intolerance, or cold intolerance. **Psychiatric:** Memory loss or confusion.

To the best of 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. I also authorized the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of Patient or Guardian Date

MEDICAL HISTORY

Please list any food or environmental allergies you may have:_____

_____

_____

Please list all medicines to which you are allergic and what the reaction was:_____

_____

What pharmacy do you use: _____

PLEASE LIST ALL CURRENT MEDICATION/ DOSAGE/ AND HOW OFTEN YOU TAKE THEM IN THE TABLE BELOW
DO NOT COMPLETE IF YOU HAVE A WRITTEN LIST

MEDICATION NAME	DOSAGE	INSTRUCTION	PRESCRIBER

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_____ _____

Signature of Patient or Guardian Date