# 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