PATIENT MEDICAL HISTORY FORM

Name:_____ **Date of Birth:**_____ **Today's Date:**_____ **Chart:**_____

Sex: Male ☐ Female ☐

Name and Location of Primary Care Medical Doctor:_____

Drug Allergies: None ☐ Yes ☐ (If yes please list):_____

Environmental Allergies: (please list):_____

Are you experiencing any of the following visual problems while wearing your glasses or contact lenses:

(please check **yes** or **no**)	YES	NO
Difficulty reading small print	☐	☐
Difficulty driving	☐	☐
Bothered by Glare/Halos	☐	☐
Eyestrain with computer work	☐	☐

Have you ever been diagnosed with, or treated for any of the following: (please check **yes** or **no**)

LUNGS:	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
Other_____	☐	☐

HEART:		
Congestive Heart Failure	☐	☐
Heart Attack(s)	☐	☐
Elevated Cholesterol	☐	☐
Other_____	☐	☐

GASTROINTESTINAL:		
Irritable Bowel Syndrome	☐	☐
Other_____	☐	☐

MUSCULO-SKELETAL:		
Arthritis	☐	☐
Lupus	☐	☐
Other_____	☐	☐

BLOOD PRESSURE:		
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Other_____	☐	☐

BLOOD:		
Anemia	☐	☐
Blood or bleeding disorders	☐	☐
Other_____	☐	☐

ENDOCRINE:	YES	NO
Diabetes	☐	☐
☐ Adult onset		
☐ Childhood onset		
Last Blood Sugar_____ Date_____		
Thyroid Problems	☐	☐
Other_____	☐	☐

NERVOUS SYSTEM:		
Hearing Problems	☐	☐
Fainting or Dizziness	☐	☐
Migraine Headaches	☐	☐
Convulsions/Epilepsy/Seizures	☐	☐
Stoke/Paralysis/TIA	☐	☐
Other_____	☐	☐

PSYCHIATRIC:		
Depression	☐	☐
Schizophrenia	☐	☐
Anxiety	☐	☐
Other_____	☐	☐

GENITOURINARY:		
Kidney Disease	☐	☐
Pregnant Now?	☐	☐

CANCER:		
Type (s)_____	☐	☐

Please list all prescribed and over the counter medications you are currently taking:

Name of medication	For what condition/ Dosage?	Name of medication	For what condition/ Dosage?

OVER

Patient Name_____ **Chart#** _____

PATIENTS EYE HISTORY:

Do you have, or have you ever had, any of the following:
(please check **yes** or **no**)

	YES	NO
Cataracts	☐	☐
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Retinal Problems	☐	☐
Diabetic Retinopathy	☐	☐
Eye Muscle Problems	☐	☐
Optic Nerve Problems	☐	☐
Other_____	☐	☐

Do you use any eye drops?
Yes ☐ No ☐

If yes, please list names and dosage of drops:_____

FAMILY EYE HISTORY:

Does anyone in your immediate family
(**blood relatives**) have any of the following:
(Please check **yes** or **no**)
Relationship to patient (*Sibling, Parent, or Grandparent*)

	YES	NO	
Cataracts	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Diabetic Retinopathy	☐	☐	_____
Eye Muscle Problems	☐	☐	_____
Retinal Detatchement	☐	☐	_____
Blindness	☐	☐	_____
Other Ocular Problems	☐	☐	_____

Explain_____

CONTACT LENSES:

Have you ever worn contact lenses? Yes ☐ No ☐
If yes, Doctor's office that provided last prescription:

_____

Are you interested in contact lenses today? Yes ☐ No ☐

Which pharmacy do you use for your prescriptions? _____ _____
Name Location

I have answered the above questions to the best of my knowledge.

_____ _____
Patient or Guardian's Signature **Date**

Technician will review this section with you.

Previous Eye Surgeries:	Date	Surgeon
Cataract Extraction/IOL	OD _____	
	OS _____	
Yag Capsulotomy	OD _____	
	OS _____	
Retinal Detach Repair	OD _____	
	OS _____	
Retinal Laser Therapy		
PRP	OD _____	
	OS _____	
Focal Macular Laser	OD _____	
	OS _____	
Glaucoma Surgery		
Argon Laser Trabeculoplasty	OD _____	
	OS _____	
Trabeculectomy	OD _____	
	OS _____	
Glaucoma Drainage Implant	OD _____	
	OS _____	
_____	OD	OS _____
_____	OD	OS _____
Other:	Date	
_____	OD	OS _____
_____	OD	OS _____
_____	OD	OS _____

FOR OFFICE USE ONLY
Reviewed/Amended on (please date and initial): _____
_____
_____