

EYE & MEDICAL HEALTH HISTORY FORM

Today's Date: _____ Patient Name _____ Age: _____

To help the doctor properly evaluate and treat your eye condition, please complete all information below.

Have you recently experienced any of the following symptoms with your eyes? (Please check all that apply) No Symptoms

- | | | | | |
|--|--|---|--|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Dry Eye | <input type="checkbox"/> Fluctuating Vision | <input type="checkbox"/> Light Sensitivity | <input type="checkbox"/> Redness |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of Vision | <input type="checkbox"/> Sandy or Gritty |
| <input type="checkbox"/> Crusting | <input type="checkbox"/> Flashes of Lights | <input type="checkbox"/> Itching | <input type="checkbox"/> Mucous Discharge | <input type="checkbox"/> Tearing or Watery |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Floaters | <input type="checkbox"/> Injury | <input type="checkbox"/> Pain | <input type="checkbox"/> Other _____ |

Are you needing new glasses today? Yes No Only if necessary

Are you needing new contact lenses today? Yes No

CONTACT LENS HISTORY:

Have you worn contact lenses before? Yes No If yes, when did you last wear them? _____

How many hours do you typically wear your contacts? _____ Do you sleep in your contacts? Never Sometimes Always

What brand are your contacts? _____ Which cleaning solution do you use? _____

Please describe any problems you are having with your contacts: _____

ADDITIONAL VISION NEEDS:

Please list any sports, hobbies, or activities you do that may require special vision needs: _____

How many hours do you use a computer per day? _____

EYE HEALTH HISTORY:

Date of last eye exam: _____ Date of last eye dilation: _____ Previous Doctor: _____

Do you currently or have you previously had any of the following conditions with your eyes? NONE

- Crossed/Lazy Eye Blindness Cataracts Glaucoma Macular Degeneration Retinal Detachment Eye Surgery Injury Infection

FAMILY EYE HISTORY: Do any family members (parents, grandparents, brothers, sisters) have any of the following conditions? NONE

- Glaucoma Cataracts Macular Degeneration Retinal Detachment Crossed/Lazy Eye

MEDICAL HEALTH HISTORY:

Primary Care Physician: _____ Date of last visit: _____ How often do you see your doctor? _____

Please check the box if you have any of the following conditions:

GENERAL

- Cancer _____
 Developmental Disability
 Fatigue
 Fever
 Weight Gain
 Weight Loss

EAR, NOSE, THROAT

- Ear Ache
 Hearing Loss
 Sinus Problems
 Dry Mouth
 Laryngitis

CARDIOVASCULAR

- Heart Disease
 High Blood Pressure
 Irregular Heartbeat
 Stroke
 Vascular Disease

RESPIRATORY

- Asthma
 Bronchitis
 Emphysema
 COPD

GENITOURINARY

- Kidney
 Bladder
 Prostate Disease
 STD _____

GASTROINTESTINAL

- Chron's Disease
 Colitis
 Hepatitis A / B / C
 Heartburn
 Ulcer

MUSCULOSKELATAL

- Arthritis
 Fibromyalgia
 Muscular Dystrophy
 Head/Neck Injury

INTEGUMENTARY

- Eczema
 Growths
 Psoriasis
 Rash
 Rosacea

NEUROLOGICAL

- Cerebral Palsy
 Migraines
 Multiple Sclerosis
 Paralysis
 Seizures
 Tumor

PSYCHIATRIC

- Anxiety
 Depression
 Insomnia
 Mental Illness

ENDOCRINE

- Diabetes Type I
 Diabetes Type II
 Hyperthyroid
 Hypothyroid

HEMATOLOGIC

- Anemia
 High Cholesterol
 Excessive Bleeding

ALLERGIC/IMMUNOLOGIC

- Environmental Allergies
 Lupus
 Rheumatoid Arthritis

HIV
OTHER: _____

FAMILY MEDICAL HISTORY: Do any family members have any of the following conditions? NONE

- Cancer Diabetes Heart Disease High Blood Pressure Thyroid Other _____

List any Injuries, Surgeries, or Hospitalizations you have had: _____

List all MEDICATIONS you are currently taking: _____

List all VITAMINS or SUPPLEMENTS you are taking: _____

List all over-the-counter EYE DROPS you are currently using: _____

List any ALLERGIES to MEDICATIONS: _____

FEMALES: Are you currently pregnant or nursing? Yes No

SOCIAL HISTORY:

Do you smoke? Never a Smoker Former Smoker Occasional Smoker Every day Smoker

Do you drink alcohol? Never Socially Daily

Do you use illegal drugs? No Yes Previous History of Abuse

VITALS: Height: _____ feet _____ inches Weight: _____ lbs.

Patient or Guarantor Signature: _____ Date: _____