Medical History **Today's Date: _____**

Do you have any allergies to medication? Yes_____ No _____ if yes, explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications or home remedies):

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Are you pregnant and/or nursing? Yes No N/A

Do you wear glasses? Yes No if yes, how old is your present pair of lenses? _____

Do you wear contact lenses? Yes No if yes, how old is your present pair of lenses? _____

Type of contact lenses: rigid soft extended wear other Are they comfortable? Yes No

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	Yes	No	Unknown	Relationship to you
Blindness	☐	☐	☐	_____
Cataracts	☐	☐	☐	_____
Cross Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other _____	☐	☐	☐	_____

Social History ***(This information is kept strictly confidential, however, you may discuss this portion directly with the doctor if you prefer)***

Yes, I would prefer to discuss my social history information directly with my doctor.

Do you drive? Yes No If yes, do you have visual difficulty when driving? Yes No

If yes, please describe: _____

Do you use tobacco products? Yes No If yes, Type/amount/how long:

Do you drink alcohol? Yes No If yes, Type/amount/how long:

Do you use illegal drugs? Yes No If yes, Type/amount/how long:

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis None

Review of Systems
Do you currently, or have you ever had any problems in the following areas: (if unknown then leave blank)

Systems

	Yes	No
Constitutional		
Fever, weight loss/gain	☐	☐
Neurological		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Eyes		
Glacuma	☐	☐
Cataracts	☐	☐
Loss of vision	☐	☐
Blurred vison	☐	☐
Distorted vison/halos	☐	☐
Loss of side vision	☐	☐
Double vision	☐	☐
Dryness	☐	☐
Mucus discharge	☐	☐
Redness	☐	☐
Sandy or gritty feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign body sensation	☐	☐
Excess tearing/watering	☐	☐
Glare/light sensitivity	☐	☐
Eye pain or soreness	☐	☐
Chronic infection of eye or lid	☐	☐
Sties or chalazion	☐	☐
Flashes/floaters in vision	☐	☐
Tired eye	☐	☐
Lazy eye	☐	☐
Prominent eye	☐	☐
Endocrine		
Thyroid	☐	☐
Other glands	☐	☐

	Yes	No
Ears, Nose, Mouth, Throat		
Allergies/hay fever	☐	☐
Sinus congestion	☐	☐
Runny nose	☐	☐
Post- nasal drip	☐	☐
Chronic cough	☐	☐
Dry throat/mouth	☐	☐
Respiratory		
Asthma	☐	☐
Chronic bronchitis	☐	☐
Emphysema	☐	☐
Vascular/Cardiovascular		
Diabetes	☐	☐
Heart Pain	☐	☐
High blood pressure	☐	☐
Vascular disease	☐	☐
Gastroenterology		
Diarrhea	☐	☐
Constipation	☐	☐
Urology		
Kidney/bladder	☐	☐
Musculoskeletal		
Rheumatoid arthritis	☐	☐
Muscle pain	☐	☐
Joint pain	☐	☐
Hematology		
Anemia	☐	☐
Easy bruising	☐	☐
Psychology		
Memory Loss	☐	☐
Depression	☐	☐
Anxiety	☐	☐ ∴

If you answered yes to any of these above or have a condition not listed. Please explain and list medications:

_____

_____

_____

_____

_____