MEDICAL HISTORY

NAME ________________________________ **DATE**______________ **INSURANCE**____

REFERRED BY _________________________ PRIMARY CARE MD ____

LAST EYE EXAM _______________________ OPTOMETRIST/ OPTICIAN ____

PAST EYE HISTORY ____

EYE SURGERY/ LASER YES/NO ____

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, personal hygiene, cooking, cleaning, etc.? YES/ NO

Do you wear glasses/ contact lenses? YES/ NO

Do you drive? YES/ NO

Occupation ___________________

Marital Status: *Single/ Married/ Divorced/ Widowed*

Alcohol- *None/ Social/ 2-3x wk/with dinner*

Smoking- *None/ 0-1 ppd/1 + ppd*

Exercise- *None/ Occasionally/ Weekly/ Daily*

Other

FAMILY HISTORY **(Mother, Father, Grandparents, Siblings)**

Has any member of your family had these diseases (circle all that apply)? **YES** **NO** **UNKNOWN**

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis

Other heritable disease:

SYSTEMIC MEDICAL HISTORY: Do you ***currently*** have any problems in the following areas? If YES, please provide information.

	YES	NO	Details
GENERAL/ CONSTITUTIONAL (fever, heat stroke, weight loss/gain, unusually tired, etc.)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, running nose, sinus congestion, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high blood pressure, chest pain, racing pulse, arrhythmia, etc.)			
RESPIRATORY (congestion, wheezing, shortness of breath, asthma, emphysema, bronchitis, etc.)			
GASTROINTESTINAL (stomach upset, gastritis, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, incontinence, impotence, etc.)			
FEMALES Are you pregnant? Nursing? Breast problems, etc.			
MUSCLES, BONES, JOINTS (joint pain, back pain, muscle pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, skin cancer, acne, rosacea, etc.)			
NEUROLOGICAL (numbness, headache, migraine, seizures, stroke, paralysis, tremor, multiple sclerosis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia, dementia, etc.)			
ENDOCRINE (diabetes, hypo/ hyperthyroid, myasthenia gravis, etc.)			
BLOOD/ LYMPH (bleeding, cholesterolemia, anemia, blood transfusion, etc.)			
ALLERGIC/ IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, hay fever, etc.)			

SYSTEMIC MEDICATIONS____

ASPIRIN/ COUMADIN/ PLAXIX YES/ NO ____

ALLERGY TO MEDICATIONS YES/ NO ____

Physician's Signature _______________________________