Patient ID #_____

Medical History

Name: _____ Date: _____

Last Eye Exam *(date)*: _____ Last Eye Doctor *(name)*: _____

Last Medical Exam *(date)*: _____ Last Medical Doctor *(name)*: _____

What is your eye problem/complaint today? *Please describe this problem you are having as best as you can.*

_____

_____

Patient Ocular/Medical History

	Yes	No
Glaucoma		
Cataracts		
Macular Degeneration		
Eye Injury		
Retinal Disease		
Loss of Vision/Blindness		
Eye Turn/Strabismus		
Lazy Eye/Amblyopia		
Eye Infection		
Dry Eye		
High Blood Pressure/Hypertension		
Diabetes		
Other Disease(s)/Prematurity		
Do you wear glasses?		
Do you wear contact lenses?		
If NO, would you like to?		
Have you ever had a **surgery** on your eyes?		

If YES, what was it? Why did you have it performed?

_____

Family Ocular/Medical History

	Yes	No
Glaucoma		
Cataracts		
Macular Degeneration		
Eye Injury		
Retinal Disease		
Loss of Vision/Blindness		
Eye Turn/Strabismus		
Lazy Eye/Amblyopia		
Eye Infection		
Dry Eye		
High Blood Pressure/Hypertension		
Diabetes		
Other Disease(s)/Prematurity		

Social History

	Yes	No
Do you smoke?		
If YES, do you smoke every day?		
If NO, did you used to smoke?		
Do you use recreational drugs		
Do you drink alcohol?		
Are you currently pregnant or nursing?		

What is your occupation?

What are your hobbies?

How many hours a day do you use a computer?

What is your current height?

What is your current weight?

Patient Review of Health

Do you currently have or ever had problems in the following areas?

	Yes	No
Constitution *(Fever, Weight Gain/Loss)*		
Cardiovascular/Vascular *(Diabetes, High Blood Pressure, Stroke)*		
Ears, Nose, Throat, Mouth *(Allergies, Sinus Congestion, Dryness)*		
Respiratory *(Asthma, Bronchitis, Emphysema)*		
Gastrointestinal *(Diarrhea, Constipation)*		
Genitourinary *(Genitals, Kidney, Bladder Problems)*		
Musculoskeletal *(Arthritis, Joint/Muscle Pain)*		
Integumentary *(Skin Problems)*		
Neurological *(Headaches, Migraines, Seizures)*		
Psychiatric *(Mental/Emotional Problems)*		
Endocrine *(Thyroid/Other Gland Problem)*		
Hematologic/Lymphatic *(Anemia, Bleeding Problems)*		
Allergic/Immunologic *(Allergy)*		

Medications

List all medications that you currently take (including over-the-counter, vitamins, supplements, oral contraceptives, etc.)

_____

_____

_____

What is your preferred pharmacy? _____ Phone Number: _____

Do you have any allergies to medications? _____

Do you have environmental allergies? _____