Icare Optical

Patient Medical History

EYE HISTORY

Date of Last Exam:

Currently Wear Glasses? Yes / No

Currently Wear Contacts? Yes / No

Reason for Today's Visit:

Are you currently experiencing, or have experienced, any of the following?

Blurry Vision	Yes / No
Burning	Yes / No
Discharge	Yes / No
Double Vision	Yes / No
Dryness	Yes / No
Excess Tearing / Watering	Yes / No
Eye Infection	Yes / No
Eye Pain / Soreness	Yes / No
Floaters / Spots	Yes / No
Haloes	Yes / No
Headaches	Yes / No
Itching	Yes / No
Light Flashes	Yes / No
Light Sensitivity	Yes / No
Redness	Yes / No
Sandy / Gritty Feeling	Yes / No

MEDICATION DRUG ALLERGIES

1.

2.

3.

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

AIDS / HIV	Yes / No	Family
Allergies	Yes / No	Family
Arthritis	Yes / No	Family
Asthma	Yes / No	Family
Blood/ Lymph Disorder	Yes / No	Family
Cancer	Yes / No	Family
Diabetes	Yes / No	Family
Ears, Nose, Throat Conditions	Yes / No	Family
GI (Stomach) Conditions	Yes / No	Family
Heart Disease	Yes / No	Family
High Cholesterol	Yes / No	Family
Kidney Disease	Yes / No	Family
Lupus	Yes / No	Family
Neurological Conditions	Yes / No	Family
Psychiatric Disorder	Yes / No	Family
Seizures	Yes / No	Family
Skin Conditions	Yes / No	Family
Stroke	Yes / No	Family
Thyroid Dysfunction	Yes / No	Family
Is your blood pressure:	Low / Normal / High	

Have you or a family member experienced, or been treated for, any of the following?

Cataracts	Yes / No	Family
Crossed Eye/ Lazy Eye	Yes / No	Family
Glaucoma	Yes / No	Family
LASIK or PRK	Yes / No	Family
Macular Degeneration	Yes / No	Family
Retinal Detachment	Yes / No	Family

MORE INFORMATION

Height:

Weight:

Are you pregnant or nursing? Yes / No

Do you smoke? Yes / No

Have you ever smoked? Yes / No

Signature: _____ **Date:** 02/14/2018