

Patient Medical History

EYE HISTORY

Date of Last Exam _____

Currently Wear Glasses? _____

Currently Wear Contacts? _____

Reason for Today's Visit _____

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

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

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- Blurry Vision _____
- Burning _____
- Discharge _____
- Double Vision _____
- Dryness _____
- Excess Tearing/ Watering _____
- Eye Infection _____
- Eye Pain/ Soreness _____
- Floaters/ Spots _____
- Haloes _____
- Headaches _____
- Itching _____
- Light Flashes _____
- Light Sensitivity _____
- Redness _____
- Sandy/ Gritty Feeling _____

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

Medication Drug Allergies

1. _____
2. _____
3. _____

Height _____

Weight _____

Are you pregnant or nursing? _____

Do you smoke? _____

Have you ever smoked? _____

Name: _____ Signature: _____ Date: _____