

# MEDICAL HISTORY

Name: \_\_\_\_\_ Date : \_\_\_\_\_  
Address: \_\_\_\_\_ Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Occupation \_\_\_\_\_  
Guardian (if applicable) \_\_\_\_\_ Last Eye Exam \_\_\_\_\_  
Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_  
Do you have Vision Insurance?  No  Yes If Yes, insurance carrier? \_\_\_\_\_  
Do you have Health Insurance?  No  Yes If Yes, insurance carrier? \_\_\_\_\_  
Do you have Medicare?  No  Yes  
How did you hear about us? \_\_\_\_\_

Are you interested in learning about Laser Vision Correction?  No  Yes

Are you interested in getting a prescription for contacts (maybe even just for sports)?  No  Yes

**Do you have allergies to Medications?**  No  Yes If Yes, explain

List medications you are taking: \_\_\_\_\_

List all major injuries, surgeries, or hospitalizations you have had: \_\_\_\_\_

Circle any of the following you have had:

Crossed eye    dropping lid    glaucoma    cataracts    retina disease    eye infection    eye injury

**List any eye injuries or eyes surgeries you have had in the past.**

**Are you pregnant &/or nursing?**  No  Yes

## FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children) for the following conditions

Disease/Condition	No	Yes	Relationship
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degen	<input type="checkbox"/>	<input type="checkbox"/>	_____

## SOCIAL HISTORY

This information is kept strictly confidential & you may discuss this portion directly with the doctor if you prefer.

Do you use tobacco products?  No  Yes If yes, type/amount/how long? \_\_\_\_\_

Do you drink alcohol?  No  Yes If yes, type/amount/how long? \_\_\_\_\_

Do you use illegal drugs?  No  Yes If yes, type/amount/how long? \_\_\_\_\_

Have you ever been exposed to  Gonorrhea  Hepatitis  HIV  Syphilis  Chlamydia

## Review of Systems:

Are you currently experiencing problems with any of the following?:

	No	Yes		No	Yes
<b>Constitutiona</b>			<b>Ear, Nose, &amp; Throat</b>		
Fever, Weight change	<input type="checkbox"/>	<input type="checkbox"/>	Allergies, Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
<b>Integumentary</b>			Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neurological</b>			Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<b>Respiratory</b>		
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
<b>Eyes</b>			Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<b>Vascular/ Cardiovascular</b>		
Halos around light	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<b>Gastrointestinal</b>		
Sandy/Gritty Feel	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<b>Genitourinary</b>		
Watering	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<b>Bones/ Joints/Muscles</b>		
Pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sties on lid	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters	<input type="checkbox"/>	<input type="checkbox"/>	<b>Lymphatic/Hematologic</b>		
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
<b>Endocrine</b>			Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other	<input type="checkbox"/>	<input type="checkbox"/>	Allergic/Immunologic	<input type="checkbox"/>	<input type="checkbox"/>
			Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>

## OFFICE USE

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