Medical Information & History

Date_____

Last Name_____First Name_____MI_____DOB_____

Date of Last Eye Examination _____ Location _____

Medical Allergies: (circle one) No / Yes:_____

Medications: (circle one) No / Yes:_____

Height: _____ Apx. Weight: _____ (Circle) Smoke? Y / N Use Illegal Drugs? Y / N Drink Alcohol? Y / N

Personal Eye Information

	Patient		Family		
	YES	NO	YES	NO	RELATION
Glaucoma					
Macular Degeneration					
Crossed/Lazy Eye					
Cataracts					
Eye Injury					
Eye Infection					

Eye Surgery? Y / N Kind of Surgery? _____ Date_____

Do you wear glasses? Y / N Contacts? Y / N Kind _____

General Medical Information

	Patient		Family	
	YES	NO	YES	RELATION
General / Constitutional (fatigue, insomnia, sweats/chills, weight loss/gain, trauma, difficult birth)				
Allergic / Immunologic (Asthma, Lupus, Crohn's, Cushing's, HIV, environmental allergies)?				
Cardiovascular (high blood pressure, cholesterol, heart disease, arrhythmia)?				
Ear, Nose, Mouth, Throat (hearing loss, sinus,sore throat, etc)?				
Endocrine (diabetes, high/low thyroid, etc)?				
Gastrointestinal/liver (heartburn, abdominal pain, cirrhosis, hepatitis, etc)?				
Genital/urinary (discharge, pain, blood in urine, etc)?				
Integumentary / Skin (rashes, excessive dryness, non-healing sores, eczema, psoriasis, etc)?				
Lymphatic / Hematological (blood or lymph, anemia, leukemia, etc)?				
Musculoskeletal (muscle aches, swollen joints,arthritis, etc)?				
Neurological (stroke, numbness, migraines, paralysis, seizures, etc)?				
Psychiatric (depression, anxiety, etc)?				
Respiratory (wheezing, coughing, asthma, tuberculosis, bronchitis, etc)?				
Cancer?				

Diabetes Y N Type_____ Date of Diagnosis_____

FEMALES ONLY: Are you pregnant? (circle) Y N