

## 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		RELATION
	YES	NO	YES	NO	
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