Medical History

Name: ____ Gender: Male / Female
Address: ____ Cell Phone: ______________________________
City: _________________________ State: _______ Zip: ____________ Email: __________________________________
Birthdate: ______/______/______ Last Eye Exam: ______/______/______
Occupation: _______________________ Employer: ______________________ ◯ Text ◯ Voicemail ◯ Email ◯ None
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

Medical History

List medication you take (including oral contraceptives, aspirin, over-the-counter medications, and home remedies)

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Check any of the following you've had:
◯ Age-related Macular Degeneration ◯ Inflammatory Disorder ◯ Cataract ◯ Strabismus ◯ Keratoconus
◯ Amblyopia ◯ Glaucoma Suspect ◯ Glaucoma ◯ Surgery ◯ Retinal Degeneration/Hole/Detachment
◯ Patching ◯ Eye Injury

Are you pregnant and/or nursing? ◯ No ◯ Yes
Do you wear glasses? ◯ No ◯ Yes If yes, how old is your present pair? ______________________
Do you wear contact lenses? ◯ No ◯ Yes If yes, what brand? __________________________________
Type of contact lenses: ◯ Rigid ◯ Soft ◯ Other
Are you on the computer for an extended time? ◯ Yes ◯ No
How many hours are you on the computer per day? _______

Family History

Please note any family history for the following conditions (parents, siblings, children; living or deceased):

Disease/Condition	**Check your family relations if applicable**
Cancer	Father ◯ Mother ◯ Brother(s) ◯ Sister(s) ◯ Son(s) ◯ Daughter(s) ◯
Type 1 Diabetes	Father ◯ Mother ◯ Brother(s) ◯ Sister(s) ◯ Son(s) ◯ Daughter(s) ◯
Type 2 Diabetes	Father ◯ Mother ◯ Brother(s) ◯ Sister(s) ◯ Son(s) ◯ Daughter(s) ◯
Hypertension	Father ◯ Mother ◯ Brother(s) ◯ Sister(s) ◯ Son(s) ◯ Daughter(s) ◯
Hypothyroid Disease	Father ◯ Mother ◯ Brother(s) ◯ Sister(s) ◯ Son(s) ◯ Daughter(s) ◯
Hyperthyroid Disease	Father ◯ Mother ◯ Brother(s) ◯ Sister(s) ◯ Son(s) ◯ Daughter(s) ◯
Cataract	Father ◯ Mother ◯ Brother(s) ◯ Sister(s) ◯ Son(s) ◯ Daughter(s) ◯
Macular Degeneration	Father ◯ Mother ◯ Brother(s) ◯ Sister(s) ◯ Son(s) ◯ Daughter(s) ◯
Glaucoma	Father ◯ Mother ◯ Brother(s) ◯ Sister(s) ◯ Son(s) ◯ Daughter(s) ◯

Social History

This information is kept strictly confidential. However you may discuss this portion directly with the doctor if you prefer. ◯ Yes, I prefer to discuss my social history information directly with the doctor.

Do you drive? ◯ No ◯ Yes If yes, do you have visual difficulty when driving? ◯ No ◯ Yes
If yes, please describe: ____
Do you use tobacco products? ◯ No ◯ Yes
Are you a: ◯ Former Smoker ◯ Current Occasional Smoker ◯ Current Every day Smoker ◯ Never Smoked
Do you drink alcohol? ◯ No ◯ Yes

Name: ____ Date: ____/____/________

Review of Symptoms *(Check any that apply to you):*

Eyes
- Itching ◯
- Diplopia ◯
- Burning ◯
- Mattering ◯
- Loss of Vision ◯
- Photophobia ◯
- Redness ◯
- Floaters ◯
- Loss of Sharpness ◯
- Flashes ◯
- Tearing ◯
- Other: ___________________

Constitutional
- Developmental Disorders ◯
- Cancer ◯
- Fatigue Syndrome ◯
- Other: ___________________

Ear, Nose, Mouth, Throat
- Sinusitis ◯
- Dry Mouth ◯
- Hearing Loss ◯
- Laryngitis ◯
- Other: ___________________

Neurological
- Epilepsy ◯
- Multiple Seizures ◯
- Tumor ◯
- Cerebral Palsy ◯
- Stroke/CVA ◯
- Migraine ◯
- Other: ___________________

Psychiatric
- Depression ◯
- Bipolar ◯
- Anxiety ◯
- Attention Deficit ◯
- Other: ___________________

Vascular/Cardiovascular
- Vascular Disease ◯
- Heart Disease ◯
- Hypertension ◯
- Congestive Heart Failure ◯
- Other: ___________________

Respiratory
- Cigarette Smoker ◯
- Bronchitis ◯
- COPD ◯
- Emphysema ◯
- Asthma ◯
- Sleep Apnea ◯

Gastrointestinal
- Celiac Disease ◯
- Crohn's Disease ◯
- Ulcer ◯
- Colitis ◯
- Acid Reflux ◯
- Other: ___________________

Genitourinary
- Kidney Disease ◯
- STD-Herpetic/Chlamydia ◯
- Prostate Disease/Cancer ◯
- Pregnant/Nursing ◯
- Other: ___________________

Musculoskeletal
- Arthritis ◯
- Ankylosing Spondylitis ◯
- Fibromyalgia ◯
- Muscular Dystrophy ◯
- Osteoarthritis ◯
- Gout ◯
- Other: ___________________

Integumentary
- Herpes Simplex/Cold Sores ◯
- Herpes Zoster/Shingles ◯
- Rosacea ◯
- Psoriasis ◯
- Eczema ◯
- Other: ___________________

Endocrine
- Diabetes Type 1 ◯
- Diabetes Type 2 ◯
- Thyroid Dysfunction ◯
- Hormonal Dysfunction ◯
- Other: ___________________

Hematologic/Lymphatic
- Large Volume Blood Loss ◯
- Anemia ◯
- Ulcer ◯
- High Cholesterol ◯
- Other: ___________________

Allergic/Immunologic
- Environmental Allergies ◯
- Lupus ◯
- Rheumatoid Arthritis ◯
- Drug Allergies ◯
- Please List: ________________

  ____
- Sjogren's Syndrome ◯
- Other: ____________________