MEDICAL HISTORY / REVIEW OF SYSTEMS

(Patient Please Print and Fill in Both Sides Completely)

NAME: ______________________ CHART #: ______________ DATE: __________

Name/Address/Phone Number of your Primary Doctor: ______________________________________

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EYE HISTORY

	Yes No		Yes No		Yes No
Lazy / Cross Eyed		Glaucoma		Retinal Disease	
Blind Eye		Dry Eyes		Eye Pain	
Cataracts		Baggy Eyelids		Other, Please Explain__________	
Double Vision		Eye Disease / Injury		____________________	

DO YOU HAVE A FAMILY HISTORY OF:

	Yes No		Yes No		Yes No
Diabetes		Glaucoma		Retinal Disease	
Macular Degeneration		Heart Disease		Arthritis	
Cancer		High Blood Pressure			

Do You Wear Contacts?: Yes No Type: Soft Hard How Many Years?: ______________

Last Day Worn ______________ Do You Wear Monovision Contacts (One for reading, one for distance)?: Yes No

PLEASE ANSWER ALL OF THE FOLOWING QUESTIONS TO THE BEST OF YOUR ABILITY:

Date of Last Eye Exam: __________ Doctor's Name: ______________________________

Are You Using Eye Drops? Yes No Name of Drop: ______________________________

How Many Times a Day? ________

HAVE YOU EVER HAD EYE SURGERY? Yes No Type of Surgery?____________________

Which Eye? Right Eye Date: ____________

Left Eye Date: ____________

HAVE YOU EVER HAD OR BEEN TREATED FOR:

	Yes No		Yes No		Yes No
Vertigo		Cancer		**Tuberculosis**	
Arthritis		High Blood Pressure		**Heart Condition**	
Head Injury		Headaches		**Liver Condition**	
Thyroid Condition		Sinus Problems		**Chronic Cough**	
Muscle Pain		Difficulty Sleeping		**Complications with Anesthesia**	
Weight/Hair Loss		Abdominal Pain		**Motion Sickness**	
Shortness of Breath		Palpitations		**Excessive Bleeding**	
Anxiety/Depression		**Latex Allergy**		**Kidney Condition**	
Skin Rash		**Stroke**		**Neurological Condition**	
Asthma		**Diabetes**		**Gastro/Intestinal Condition**	
Hearing Loss		**Hepatitis**		**Lung Condition**	

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE EXPLAIN. PLEASE DESCRIBE ANY MEDICAL CONDITION OR SURGERY YOU MAY HAVE/HAD THAT IS NOT LISTED ABOVE.

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	Yes No	
Do You Smoke?		How Much Per Day? __________
Do You Drink Alcohol?		How Much Per Day? __________
Do You Drink Caffeine?		How Much Per Day? __________

PLEASE SEE OTHER SIDE

DRUG ALLERGY: ____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: ______________________________________

Name/Dose/How Often	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE

PATIENT SIGNATURE: ____ DATE: ______________

(OFFICE USE ONLY)

Date/Initial: ________________ No Change: ______ Updated: ______________________

Date/Initial: ________________ No Change: ______ Updated: ______________________

Date/Initial: ________________ No Change: ______ Updated: ______________________

Date/Initial: ________________ No Change: ______ Updated: ______________________

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