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: _____

_____

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**	❑	❑
Do You Wear Hearing Aids	❑	❑						

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. _____

_____

_____

_____

_____

_____

	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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