VisionCare Specialists Medical History Form

Name:_____ Date of Birth:_____

What is the main reason for your visit today?_____

Please check if you are experiencing any of the following:

☐ Dry eyes	☐ Blur at Distance	☐ Glare
☐ Red eyes	☐ Blur at Near	☐ Floaters
☐ Itchy eyes	☐ Blur at Computer	☐ Vision Loss
☐ Irritated eyes	☐ Eye strain	Other:

Please check if **you or anyone in your family** has ever experienced the following eye problems:

	Yourself	Family		Yourself	Family
Cataracts	☐	☐	Lazy eye	☐	☐
Cataract surgery	☐	☐	Eye turn	☐	☐
Glaucoma	☐	☐	Eye turn surgery	☐	☐
Macular Degeneration	☐	☐	Eye trauma	☐	☐
Retinal Detachment	☐	☐	Keratoconus	☐	☐
Diabetic retinopathy	☐	☐	Other:_____		

Have **you or anyone in your family** ever been diagnosed with or have had a significant problem with:

	Yourself	Family		Yourself	Family
High blood pressure	☐	☐	Headaches/Migraines	☐	☐
Diabetes	☐	☐	Arthritis	☐	☐
Heart disease	☐	☐	Mental health	☐	☐
High cholesterol	☐	☐	Currently pregnant	☐	
Stroke	☐	☐	Smoking	☐	
Cancer	☐	☐			
Type(s)_____			Other: _____		

Please list any allergies (environmental or medication) that you may have:

_____ _____ _____

Please give a complete list of medications that you are currently taking:

Medication	Reason taken (if known)	Dosage (if known)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____