Ocular & Medical History:

Patient Name _____ Age _____ Date _____
Do you wear glasses? □ Yes □ No How old is your prescription? _____
Do you wear contacts? □ Yes □ No Type? □ soft □ gas permeable Cleaning System _____

Do you currently or have you ever had any problems in the following areas:
Please list any medications and/or important details related to the problem in the space below

Ocular		**Yes**	**No**	**?**	
Eyes:	Injuries	□	□	□	_____
	Diseases	□	□	□	_____
	Surgeries	□	□	□	_____
	Lazy Eye	□	□	□	_____
	Blurred/distorted vision	□	□	□	_____
	Double vision	□	□	□	_____
	Dry eyes	□	□	□	_____
	Mucous discharge	□	□	□	_____
	Redness	□	□	□	_____
	Sandy/gritty feeling	□	□	□	_____
	Itching or Burning	□	□	□	_____
	Loss of side vision	□	□	□	_____
	Excess tearing/watering	□	□	□	_____
	Glare/ Light sensitivity	□	□	□	_____
	Eye pain or soreness	□	□	□	_____
	Eyelid infections	□	□	□	_____
	Flashes or floaters	□	□	□	_____

Is there a history of any eye problems in **your family** more serious than glasses? If yes, please explain. _____
_____
What is the name of your family/medical doctor? _____ Last medical exam: _____
List all major surgeries, and/or hospitalizations _____
_____
_____
Do you have any allergies to medications? □ Yes □ No If yes, explain: _____
_____
Are you pregnant and/or nursing? □ Yes □ No

~ TURN OVER ~

Medical History:

Do you currently or have you ever had any problems in the following areas:
Please list any medications and/or important details related to the problem in the space below

CIRCLE CONDITION & CHECK→	Yes	No	?	
ENDOCRINE				
Diabetes	□	□	□	_____
Thyroid/Other Glands	□	□	□	_____
VASCULAR / CARDIOVASCULAR				
High Blood Pressure	□	□	□	_____
Heart/Cholesterol	□	□	□	_____
RESPIRATORY				
Asthma/ Emphysema	□	□	□	_____
Chronic Bronchitis/COPD	□	□	□	_____
BONES / JOINTS / MUSCLES				
Rheumatoid Arthritis	□	□	□	_____
Osteoarthritis (age related)	□	□	□	_____
Joint/Muscle Pain	□	□	□	_____
Osteoporosis	□	□	□	_____
EARS / NOSE / MOUTH / THROAT				
Hay Fever/Allergies/Sinus	□	□	□	_____
Dry Throat/Mouth	□	□	□	_____
GENITOURINARY				
Genitals/ Kidney/Bladder	□	□	□	_____
LYMPHATIC / HEMATOLOGIC				
Anemia/Bleeding	□	□	□	_____
NEUROLOGICAL				
Headaches/Migraines	□	□	□	_____
Seizures/Psychiatric	□	□	□	_____
Dyslexia/Illiterate	□	□	□	_____
DERMATOLOGIC (Skin)	□	□	□	_____
GASTRO				
(please list)	□	□	□	_____
CANCER	□	□	□	_____

Preferred Pharmacy (Name and location) _____
Please list any other medications, vitamins, or herbal supplements not listed above:_____
_____
Please list any other health concerns/problems you have not addressed above: _____
_____

Social History:

Occupation _____ Hobbies _____
The following information is strictly confidential. You may discuss this portion directly with the doctor if you prefer.
Do you smoke? □ no □ yes If yes, type/amount/how long: _____
Do you drink alcohol? □ no □ yes If yes, type/amount/how long: _____
Do you use recreational/illegal drugs? □ no □ yes If yes, type/amount/how long_____
Have you ever been exposed to or infected with: □ HIV □ Syphilis □ Gonorrhea □ Hepatitis (X if yes)