Medical and Ocular History

Patient's Name_____Date of birth_____

Do you have any allergies to medications? If yes, please list_____

List all medications you currently take (including eye drops, oral contraceptives, aspirin, vitamins and supplements)

_____

_____

_____

Personal Medical History

Do you currently have or have ever had any of the following conditions? Check those that apply.

General Health
- ❒ Currently Pregnant or Nursing
- ❒ Developmental Disability
- ❒ Cancer - Type_____
- ❒ Tobacco Use
  Type_____Amount_____
- ❒ Alcohol Use
  Type_____Amount_____
- ❒ Drug Use

Allergic/Immunologic
- ❒ Environmental Allergies
- ❒ Chronic Sinus Congestion/Cough
- ❒ Lupus / Rheumatoid Arthritis

Cardiovascular
- ❒ Hypertension/High Blood Pressure
- ❒ Stroke
- ❒ Heart Disease
- ❒ High Cholesterol

Endocrine
- ❒ Diabetes
- ❒ Hypothyroid / Hyperthyroid

Gastrointestinal
- ❒ Crohns / Colitis / Ulcer
- ❒ Other_____

Respiratory
- ❒ Asthma
- ❒ Emphysema
- ❒ Chronic Bronchitis

Eyes
- ❒ Retinal Detachment/Disease
- ❒ Glaucoma/Optic nerve disorder
- ❒ Cataracts
- ❒ Macular Degeneration
- ❒ Lazy/Crossed Eye
- ❒ Corneal Disease
- ❒ Eye Injury
- ❒ Eye Allergies
- ❒ Prism In glasses
- ❒ Double Vision
- ❒ Dry Eyes

Dermatologic
- ❒ Eczema
- ❒ Rosacea
- ❒ Psoriasis

Musculoskeletal
- ❒ Muscular Dystrophy
- ❒ Osteoarthritis
- ❒ Ankylosing Spondylitis
- ❒ Fibromyalgia

Hematologic/Lymphatic
- ❒ Bleeding Problems
- ❒ Leukemia
- ❒ Anemia

Genitourinary
- ❒ Kidney or Bladder Disease
- ❒ Other_____

Psychiatric
- ❒ Depression
- ❒ Anxiety
- ❒ Other _____

Neurological
- ❒ Multiple Sclerosis
- ❒ Seizures
- ❒ Head Trauma
- ❒ Headaches/Migraines

Infectious Disease
- ❒ AIDS/HIV
- ❒ Hepatitis
- ❒ Tuberculosis
- ❒ STDs_____

Other Health Conditions
- ❒ _____

Have you had any major ocular injuries or surgeries? Please list them.

_____

_____

Family History

Does any family member (parents, grandparents, siblings, or children) currently have or had any of the following conditions? Please write the relationship to you.

- ❒ Blindness _____
- ❒ Cataract_____
- ❒ Retinal Detachment_____
- ❒ Glaucoma_____
- ❒ Macular Degeneration_____
- ❒ High Blood Pressure_____
- ❒ Diabetes_____
- ❒ Thyroid Disease_____
- ❒ Cancer_____
- ❒ Heart Disease_____

HISTORY REVIEW For Office Use only

Provider/Tech_____ Date_____ Provider/Tech_____ Date _____ Provider/Tech_____ Date_____
Provider/Tech_____ Date_____ Provider/Tech_____ Date _____ Provider/Tech_____ Date_____
Provider/Tech_____ Date_____ Provider/Tech_____ Date _____ Provider/Tech_____ Date_____