Patient Ocular and Medical History

Patient Name: _____ □ Male □ Female Date: _____

Name of Primary Care Physician:_____ Phone #_____

Other Medical Doctor(s): _____

Last Eye Exam: Date: _____ Location: _____ Doctor: _____

Personal Medical History:

Do you have any allergies to medications? □ Yes □ No If yes, list: _____

Do you have any seasonal/food allergies? □ Yes □ No If yes, list: _____

Are you pregnant? □ Yes □ No

List all Medications (Prescription/Over the Counter):

Name	Dosage	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

List all major injuries, surgeries, and/or hospitalizations you have had: _____

_____

List any eye surgeries: _____

Have you ever been diagnosed with:

	YES	NO		YES	NO
Glaucoma	□	□	Diabetes	□	□
Cataracts	□	□	Heart Disease	□	□
Retinal Detachment	□	□	High Blood Pressure	□	□
Eye Injury	□	□	High Cholesterol	□	□
"Lazy Eye"	□	□	Stroke	□	□
Diabetic Eye Disease	□	□	Cancer _____	□	□
Thyroid Eye Disease	□	□	Thryoid Disease	□	□
Macular Degeneration	□	□	Multiple Sclerosis	□	□
Other _____			HIV/AIDS	□	□
_____			Migraines	□	□
			Asthma/Ephysema (please circle)	□	□

Family Medical History: Has anyone in your family had: (if yes please list relationship to you)

	YES	NO	
Macular Degeneration	□	□	_____
Glaucoma	□	□	_____
"Lazy Eye"	□	□	_____
Cataracts	□	□	_____
Diabetes	□	□	_____
High Blood Pressure	□	□	_____
Heart Disease	□	□	_____
Other _____	□	□	_____

(OVER)

Social History:

Do you drive? □ Yes □ No

Do you use tobacco products? □ Yes □ No Type: _____ Quantity: _____

Do you drink alcohol? □ Yes □ No Type: _____ Quantity: _____

Do you use any other drugs? □ Yes □ No Type: _____ Quantity: _____

Check if you have been exposed to or infected with: □ Gonorrhea □ Syphilis □ HIV □ Hepatitis

Review of Systems:

Do you currently have or ever had any problems in the following areas:

Constitutional	**Yes**	**No**	**?**	**Ear, Nose, Mouth, Throat**	**Yes**	**No**	**?**
Fever	□	□	□	Seasonal Allergies	□	□	□
Weight Changes/Loss of appetite	□	□	□	Sinus Congestion	□	□	□
Fatigue/Weakness	□	□	□	Dry Mouth/Throat	□	□	□
Integumentary (Skin)				**Respiratory**			
Rosacea	□	□	□	Asthma	□	□	□
Acne	□	□	□	Ephysema	□	□	□
Neurological				Chronic Bronchitis	□	□	□
Headaches	□	□	□	**Vascular/Cardiovascular**			
Migraines	□	□	□	Diabetes	□	□	□
Seizures	□	□	□	Hypertension	□	□	□
Stroke	□	□	□	High Cholesterol	□	□	□
Eyes				Vascular Disease	□	□	□
Blurred Vision	□	□	□	**Gastrointestinal**			
Distorted Vision/Halos	□	□	□	Chronic Diarrhea	□	□	□
Loss of Side Vision	□	□	□	Crohns Disease	□	□	□
Double Vision	□	□	□	**Genitourinary**			
Mucous Discharge	□	□	□	Kidney/Bladder Disease	□	□	□
Redness	□	□	□	**Musculoskeletal**			
Sandy/Gritty Feeling	□	□	□	Rheumatoid Arthritis	□	□	□
Itching	□	□	□	Osteoarthritis	□	□	□
Burning	□	□	□	Ankylosing Spondylitis	□	□	□
Dryness	□	□	□	**Lyphatic/Hematologic**			
Glare/Light Sensitivity	□	□	□	Anemia	□	□	□
Eye Pain or Soreness	□	□	□	Bleeding Disorders	□	□	□
Eye Trauma/Injury	□	□	□	**Endocrine**			
Flashes	□	□	□	Thyroid Disease	□	□	□
Floaters in Vision	□	□	□	**Psyhological**	□	□	□
Eye Strain	□	□	□	**Other**	□	□	□

Please list any other health related issues you have been diagnosed with not mentioned above:_____

_____

_____

Doctor's Notes:

Reviewed By:

Clinician: _____ Date: _____

Clinician: _____ Date: _____

Clinician: _____ Date: _____