

# 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	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>
“Lazy Eye”	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Diabetic Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer _____	<input type="checkbox"/>
Thyroid Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>
Other _____			HIV/AIDS	<input type="checkbox"/>
			Migraines	<input type="checkbox"/>
			Asthma/Ephysema (please circle)	<input type="checkbox"/>

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

	YES	NO	
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
“Lazy Eye”	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

**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:

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

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: \_\_\_\_\_