

MEDICAL HISTORY INFORMATION

Last Name: _____ **First Name:** _____ **D.O.B.:** _____ **Age:** _____
Male **Female**

Reason for visit today: _____

Past, Family, & Social History (Please check ALL appropriate boxes.)

Patient Past:

- Eye Injury:
- Glaucoma:
- Cataract:
- Macular Degeneration:
- Surgery:
- Hypertension:
- Diabetic:
- Cancer:

Family History:

- Glaucoma:
- Cataract:
- Macular Degeneration:
- Surgery:
- Hypertension:
- Diabetic:
- Cancer:
- Other:

Patient Social History:

- Smoke:
- Alcohol:
- Other:

Occupational:

- Do you have any work related special visual needs?
Y N If yes, please explain: _____

Do you have any of the following? (Please check ALL appropriate boxes.)

Allergic/Immunologic:

- NONE
- Environmental Allergy
- Rheumatoid Arthritis
- Lupus
- Other _____

Gastrointestinal:

- NONE
- Crohn's
- Colitis
- Ulcer
- Digestive
- Other _____

Integumentary/Skin:

- NONE
- Eczema
- Rosacea
- Psoriasis
- Other _____

Psychiatric:

- NONE
- Depression
- Panic Disorder
- Schizophrenia
- Other _____

Cardiovascular:

- NONE
- Heart Disease
- Hypertension
- Stroke
- Vascular Disease
- Other _____

Endocrine:

- NONE
- Diabetes
- Thyroid
- Hormonal
- Other _____

Musculoskeletal:

- NONE
- Fibromyalgia
- Muscular Dystrophy
- Osteoarthritis
- Ankylosing Spondylitis
- Other _____

Respiratory:

- NONE
- Asthma
- Bronchitis
- Emphysema
- Other _____

Neurological:

- NONE
- Multiple Sclerosis
- Epilepsy
- Other _____

Genitourinary:

- NONE
- STD
- Prostate
- Other _____

Constitutional:

- NONE
- Developmental Disability
- Weight Loss
- Fever
- Fatigue
- Trauma
- Other _____

Hematologic/Lymphatic:

- NONE
- Anemia
- Sickle Cell
- Blood Disease
- Other _____

Ear/Nose/Throat/Mouth:

- NONE
- Upper Resp. Tract Infect.
- Other _____

Medications:

Eye Medications:

DRUG ALLERGIES:

Do you wear Glasses? Y N

Do you wear Contacts? Y N

Are you interested in Contacts? Y N

Are you interested in Refractive Surgery? Y N

Who is your Primary Care Doctor? _____ Doctor's Phone # ? _____

Signature: _____ Date: _____