Medical History

+1( )9
www.

Name:____ **Date:**____________________

Date of Birth: ________________ **Age:**________ **Sex**: ☐ Male ☐ Female ☐ Undifferentiated ☐ Decline to Specify

Glasses/Contact Lenses (*Please check appropriate boxes below*)

Do you currently wear glasses? ☐ No ☐ Yes If yes, how old are your glasses? ______ Type? ____________

Do you currently wear contact lenses? ☐ No ☐ Yes If yes, for how long? ______ Type? ____________

Have you ever tried contact lenses? ☐ No ☐ Yes When did you last wear contacts? ____________________

Allergies (Meds/Latex/Anesthesia): ☐ No ☐ Yes If yes, which ones:____________________________

Current Medical Problems: ☐ HTN (High Blood Pressure) ☐ Elevated Lipids (High Cholesterol) ☐ Diabetes Type I ☐ Diabetes Type II ☐ Sjogren's ☐ Rheumatoid Arthritis Other:____________________________

**If applicable, are you currently or possibly pregnant?* ☐ *No* ☐ *Yes* | **If applicable, are you currently breastfeeding?* ☐ *No* ☐ *Yes*

Previous Surgeries: ____

Family History (*M-Mother, F-Father, S-Sister, B-Brother, MGM/MGF-Maternal Grandmother/Father, PGM/PGF-Paternal Grandmother/Grandfather*)

☐ Glaucoma______ ☐ Diabetes______ ☐ Cancer________ ☐ HTN (High Blood Pressure) ____ ☐ Keratoconus____

☐ Retinal Detachment____ ☐ Color Blindness____ ☐ Macular Degeneration____ ☐ Other____________________

Social History (*Please check and/or circle appropriate boxes below*)

Do you drive? ☐ No ☐ Yes

Do you drink caffeine? ☐ No ☐ Yes

If Yes, type & amount?____________

Do you drink alcohol? ☐ No ☐ Yes

If Yes, amount & how often?__________

Do you smoke tobacco? ☐ No ☐ Yes If yes, how often?__________

Do you currently vape? ☐ No ☐ Yes If yes, with/without Nicotine? ____

If Yes, have you ever tried to quit? ☐ No ☐ Yes

If Yes, when or how long ago? ____________________

Have you had passive smoke and/or vaping exposure? ☐ No ☐ Yes

Current Medications:
*Include over-the-counter ☐ No ☐ Yes ________________________________

Review of Systems: Do you currently have any of the following symptoms? (*Please check the appropriate boxes below*)

Symptom	No	Yes	Symptom	No	Yes	Symptom	No	Yes
Environmental Allergies	☐	☐	Polydipsia (Excessive Thirst)	☐	☐	Rash	☐	☐
Food Allergies	☐	☐	Polyphagia (Excessive Hunger)	☐	☐	Arthralgia (Joint Pain)	☐	☐
Chest Pressure	☐	☐	Hearing Loss	☐	☐	Joint Swelling	☐	☐
Chest Discomfort	☐	☐	Constipation	☐	☐	Muscle Weakness	☐	☐
Irregular Heartbeat	☐	☐	Diarrhea	☐	☐	Dizziness	☐	☐
Heart Palpitations	☐	☐	Vomiting	☐	☐	Gait Disturbances	☐	☐
Fatigue	☐	☐	Dysuria (Painful Urination)	☐	☐	Headache	☐	☐
Fever	☐	☐	Hematuria (Blood in Urine)	☐	☐	Emotional changes	☐	☐
Night Sweats	☐	☐	Polyuria (Excessive Urination)	☐	☐	Cough	☐	☐
Cold Intolerance	☐	☐	Bruising	☐	☐	Wheezing	☐	☐
Heat Intolerance	☐	☐	Easy Bleeding	☐	☐	Other:__________		

Eye History: Have you ever had or been told you have: (*Please check appropriate boxes below*)

☐ Cataracts	☐ Cataract Surgery	☐ Herpes Infection of the Eye	☐ Foreign Body Sensation
☐ Glaucoma (High Eye Pressure)	☐ Laser Eye Surgery	☐ Recurrent Corneal Erosion	☐ Irritation or Dryness
☐ Macular Degeneration	☐ Pterygium Surgery	☐ Blurred or Double Vision	☐ Excessive Tearing or Watering
☐ Diabetic Retinopathy	☐ Corneal Surgery	☐ Glare/ Light Sensitivity	☐ Mucous Discharge
☐ Flashes or Floaters	☐ Eyelid Surgery	☐ Distorted Vision / Halos	☐ Redness
☐ Retinal Tear/Detachment	☐ Eye Injury	☐ Loss of Vision	☐ Drooping Eyelids
☐ Keratoconus	☐ Amblyopia (Crossed/Lazy Eye)	☐ Eye Pain or Soreness	☐ Other: __________

☐ ***I understand that dilating eye drops may be used in my examination and may blur my vision, making it unsafe to drive. I will not attempt to drive until I am certain the effect of the medicine has worn off. The effect of the drops may last an hour or longer.***

My signature below indicates that the information provided above is accurate and complete to the best of my ability.

____________________________ ________________________
Signature of patient (if over 18) or patient's parent or legal guardian *Date*

____________________________ ________________________
If signed by parent/legal guardian, print name *Relationship*