

## PATIENT MEDICAL HISTORY

Name of Family Physician: \_\_\_\_\_

Date of Last Physical Check Up: \_\_\_\_\_

**CURRENT MEDICATIONS (Rx or Over the Counter)**  
(list name of medications including eye drops, vitamins & birth control pills)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ALLERGIES TO MEDICATIONS?  Yes  No  
If yes, what medications?

\_\_\_\_\_

\_\_\_\_\_

Have you had any surgeries? \_\_\_\_\_

Do you use cigarettes/tobacco or alcohol or other substances?  
 Yes  No

Have you ever been diagnosed or treated for the following health problems?

- |  |  |
|--|--|
| <input type="checkbox"/> Allergies           | <input type="checkbox"/> Integumentary (Skin)        |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Muscle/Bone                 |
| <input type="checkbox"/> Blood/Lymph         | <input type="checkbox"/> Kidney                      |
| <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Neurological                |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Psychological               |
| <input type="checkbox"/> Cholesterol         | <input type="checkbox"/> Sinus                       |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Thyroid                     |
| <input type="checkbox"/> Endocrine           | <input type="checkbox"/> Unusual weight losses/gains |
| <input type="checkbox"/> Ears/Nose Throat    |  |
| <input type="checkbox"/> Eczema/Rashes       |  |
| <input type="checkbox"/> Fatigue             |  |
| <input type="checkbox"/> Gastrointestinal    |  |
| <input type="checkbox"/> High Blood Pressure |  |

Patient Signature: \_\_\_\_\_

Last Eye Examination: \_\_\_\_\_

Name of Eye Doctor: \_\_\_\_\_

Have you ever experience, been diagnosed or treated for any of the following:

- Blurry Vision
- Burning
- Itchiness
- Crossed/eye turn
- Double Vision
- Dryness/Sandy/Gritty Eyes
- Eye Infection
- Eye Injury
- Flashes of light
- Floaters
- Itchiness
- Glaucoma
- Lazy Eye
- Macular Degeneration
- Retinal Detachment/Tear
- Tearing
- Trouble seeing at night
- Iritis/Uveitis
- Other eye disorders \_\_\_\_\_

### FAMILY MEDICAL HISTORY

Is there a family medical history of any of the following:

(please indicate who, Mother's or father's side)

- |  |                                |
|--|--------------------------------|
| <input type="checkbox"/> Blindness     | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cataracts     | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Glaucoma      | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Lazy eye      | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Macular       | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Degeneration  | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Retinal       | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Detachment    | <input type="checkbox"/> _____ |

Date: \_\_\_\_\_