MEDICAL HISTORY

Date:_____

Name:_____ Date of Birth:_____

Primary Care Physician:_____ Date of Last Medical Exam:_____

Date of Last Vision Exam: _____ Dominant Hand: ❑ Right ❑ Left ❑ Ambidextrous

Allergies to Medicines or other Substances:_____

_____

Current Medications (Prescription or Otherwise): _____

_____

Recent Hospitalizations or Surgeries: _____

SYSTEMS HISTORY

Indicate if you have ever had issues (past or present) within any of the following areas:

	Yes	No
Eyes		
Complete loss of vision	___	___
Blurred vision	___	___
Double vision	___	___
Eye injury	___	___
Eye surgery	___	___
Floaters/Flashes	___	___
Glare/Halos	___	___
Crossed or lazy eye	___	___
Cataracts	___	___
Glaucoma	___	___
Eye pain or soreness	___	___
Retinal disease	___	___
Endocrine		
Thyroid	___	___
Bones/Joints/Muscles		
Rheumatoid arthritis	___	___
Joint pain	___	___
Hematologic		
Anemia	___	___

	Yes	No
Vascular/Heart		
Diabetes	___	___
High blood pressure	___	___
Heart pain	___	___
Neurological		
Headaches	___	___
Migraines	___	___
Seizures	___	___
Respiratory		
Asthma	___	___
Chronic bronchitis	___	___
Emphysema	___	___
Skin	___	___
Psychiatric	___	___
Gastrointestinal		
Diarrhea	___	___
Ear/Nose/Throat/Mouth		
Allergies/Hay fever	___	___
Genitourinary		
Kidney/Bladder/Genital	___	___

Other _____

SOCIAL HISTORY

Do you use tobacco products? ___ ___

Do you drink alcohol? ___ ___

How much?_____

Do you use illegal drugs? ___ ___

Have you been exposed or infected with:

❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphilis

FAMILY HISTORY

Indicate any family history (parents, grandparents, siblings, children – living or deceased) for the following:

Ocular Conditions	Yes	No
Blindness	___	___
Crossed eyes	___	___
Glaucoma	___	___
Macular degeneration	___	___
Retinal detachment	___	___

Systemic Conditions	Yes	No
Diabetes	___	___
High blood pressure	___	___
Cancer	___	___
Heart Disease	___	___

Reviewed by (Doctor's Signature): _____

By signing this form, I consent to treatment for myself and/or on behalf of the minor for which this information pertains. I give permission for the doctor/s to examine, diagnose and initiate treatment as deemed appropriate. I further attest that I am the parent or legal guardian of minor and have the authority to authorize care and treatment.

Patient or Guardian Signature _____