

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

Pharmacy: _____ Location: _____

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		Yes	No
Eyes			Vascular/Heart		
Complete loss of vision	___	___	Diabetes	___	___
Blurred vision	___	___	High blood pressure	___	___
Double vision	___	___	Heart pain	___	___
Eye injury	___	___	Neurological		
Eye surgery	___	___	Headaches	___	___
Floaters/Flashes	___	___	Migraines	___	___
Glare/Halos	___	___	Seizures	___	___
Crossed or lazy eye	___	___	Respiratory		
Cataracts	___	___	Asthma	___	___
Glaucoma	___	___	Chronic bronchitis	___	___
Eye pain or soreness	___	___	Emphysema	___	___
Retinal disease	___	___	Skin	___	___
Endocrine			Psychiatric	___	___
Thyroid	___	___	Gastrointestinal		
Bones/Joints/Muscles			Diarrhea	___	___
Rheumatoid arthritis	___	___	Ear/Nose/Throat/Mouth		
Joint pain	___	___	Allergies/Hay fever	___	___
Hematologic			Genitourinary		
Anemia	___	___	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	Systemic Conditions	Yes	No
Blindness	___	___	Diabetes	___	___
Crossed eyes	___	___	High blood pressure	___	___
Glaucoma	___	___	Cancer	___	___
Macular degeneration	___	___	Heart Disease	___	___
Retinal detachment	___	___			

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 _____