MEDICAL HISTORY / REVIEW OF SYSTEMS

(Patient Please Print and Fill in Both Sides Completely)

NAME: _____ CHART #: _____ DATE: _____

Name/Address/Phone Number of your Primary Doctor: _____

_____

EYE HISTORY

	Yes	No		Yes	No		Yes	No
Lazy / Cross Eyed	☐	☐	Glaucoma	☐	☐	Retinal Disease	☐	☐
Blind Eye	☐	☐	Dry Eyes	☐	☐	Eye Pain	☐	☐
Cataracts	☐	☐	Baggy Eyelids	☐	☐	Other, Please Explain		
Double Vision	☐	☐	Eye Disease / Injury	☐	☐	_____		

DO YOU HAVE A FAMILY HISTORY OF:

	Yes	No		Yes	No		Yes	No
Diabetes	☐	☐	Glaucoma	☐	☐	Retinal Disease	☐	☐
Macular Degeneration	☐	☐	Heart Disease	☐	☐	Arthritis	☐	☐
Cancer	☐	☐	High Blood Pressure	☐	☐			

Do You Wear Contacts?: ☐ Yes ☐ No Type: ☐ Soft ☐ Hard How Many Years?: _____

Last Day Worn _____ Do You Wear Monovision Contacts (One for reading, one for distance)?: ☐ Yes ☐ No

PLEASE ANSWER ALL OF THE FOLOWING QUESTIONS TO THE BEST OF YOUR ABILITY:

Date of Last Eye Exam: _____ Doctor's Name: _____

Are You Using Eye Drops? ☐ Yes ☐ No Name of Drop: _____

How Many Times a Day? _____

HAVE YOU EVER HAD EYE SURGERY? ☐ Yes ☐ No Type of Surgery? _____

Which Eye? Right Eye Date: _____

Left Eye Date: _____

HAVE YOU EVER HAD OR BEEN TREATED FOR:

	Yes	No		Yes	No		Yes	No
Vertigo	☐	☐	Cancer	☐	☐	**Tuberculosis**	☐	☐
Arthritis	☐	☐	High Blood Pressure	☐	☐	**Heart Condition**	☐	☐
Head Injury	☐	☐	Headaches	☐	☐	**Liver Condition**	☐	☐
Thyroid Condition	☐	☐	Sinus Problems	☐	☐	**Chronic Cough**	☐	☐
Muscle Pain	☐	☐	Difficulty Sleeping	☐	☐	**Complications with Anesthesia**	☐	☐
Weight/Hair Loss	☐	☐	Abdominal Pain	☐	☐	**Motion Sickness**	☐	☐
Shortness of Breath	☐	☐	Palpitations	☐	☐	**Excessive Bleeding**	☐	☐
Anxiety/Depression	☐	☐	**Latex Allergy**	☐	☐	**Kidney Condition**	☐	☐
Skin Rash	☐	☐	**Stroke**	☐	☐	**Neurological Condition**	☐	☐
Asthma	☐	☐	**Diabetes**	☐	☐	**Gastro/Intestinal Condition**	☐	☐
Hearing Loss	☐	☐	**Hepatitis**	☐	☐	**Lung Condition**	☐	☐
Do You Wear Hearing Aids	☐	☐						

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE EXPLAIN. PLEASE DESCRIBE ANY MEDICAL CONDITION OR SURGERY YOU MAY HAVE/HAD THAT IS NOT LISTED ABOVE. _____

_____

_____

_____

_____

_____

	Yes	No	
Do You Smoke?	☐	☐	How Much Per Day? _____
Do You Drink Alchohol	☐	☐	How Much Per Day? _____
Do You Drink Caffeine	☐	☐	How Much Per Day? _____

PLEASE SEE OTHER SIDE

DRUG ALLERGY: _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

Name/Dose/How Often	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE

PATIENT SIGNATURE: _____ DATE: _____

(OFFICE USE ONLY)

Date/Initial: _____ No Change: _____ Up Dated: _____

Date/Initial: _____ No Change: _____ Up Dated: _____

Date/Initial: _____ No Change: _____ Up Dated: _____

Date/Initial: _____ No Change: _____ Up Dated: _____

Date/Initial: _____ No Change: _____ Up Dated: _____

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