

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	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Blind Eye	<input type="checkbox"/>	<input type="checkbox"/>	Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Baggy Eyelids	<input type="checkbox"/>	<input type="checkbox"/>	Other, Please Explain _____		
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Eye Disease / Injury	<input type="checkbox"/>	<input type="checkbox"/>			

DO YOU HAVE A FAMILY HISTORY OF:

	Yes	No		Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>			

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	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Liver Condition	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Complications with Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>
Weight/Hair Loss	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Motion Sickness	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety/Depression	<input type="checkbox"/>	<input type="checkbox"/>	Latex Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Condition	<input type="checkbox"/>	<input type="checkbox"/>
Skin Rash	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Condition	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Gastro/Intestinal Condition	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Lung Condition	<input type="checkbox"/>	<input type="checkbox"/>
Do You Wear Hearing Aids	<input type="checkbox"/>	<input type="checkbox"/>						

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?	<input type="checkbox"/>	<input type="checkbox"/>	How Much Per Day? _____
Do You Drink Alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	How Much Per Day? _____
Do You Drink Caffeine?	<input type="checkbox"/>	<input type="checkbox"/>	How Much Per Day? _____

PLEASE SEE OTHER SIDE

