Initial Medical History

Name _____ Date _____

Date of **birth** _____ Date of **last eye exam** _____

List any **medications** you currently take (prescription and over-the-counter):

_____

_____

Do you have **allergies** to any medications? ☐ YES ☐ NO
If YES, list the medications:

_____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):

_____

_____

List any **surgeries** you have had (cataract, tonsillectomy, appendectomy):

_____

_____

Do you ***currently*** have any problems in the following areas? If "YES", please provide information.

	YES	NO	Explanation of Problem
EYES (Glaucoma, cataract, retinal disease, etc.)			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			

	YES	NO	Explanation of Problem
GENERAL/CONSTITUTIONAL			
Fever			
Weight loss			
Other			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			
CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.)			

FAMILY HISTORY M=mother F=father S=sibling GP=grandparent

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current occupation: _____

Education (high school, vocational school, college degree): _____

Marital Status (married, divorced, single, widowed): _____

Living Arrangements: _____

Do you drive? ☐ YES ☐ NO

Do you have visual difficulty when driving? ☐ YES ☐ NO

Do you have problems with night vision? ☐ YES ☐ NO

Have you ever tried to wear contact lenses? ☐ YES ☐ NO

Do you currently wear contact lenses? ☐ YES ☐ NO

If YES, how long have you worn contact lenses? _____

Do you currently wear glasses? ☐ YES ☐ NO

If YES, how long have you had the current prescription? _____

Do you drink alcohol? ☐ YES ☐ NO If YES: occasional 1 per day 2-3 /day 4+ /day

Do you smoke? ☐ YES ☐ NO If YES: occasional ½ pack/day 1 pack/day 1+ pack

Have you ever had a blood transfusion? ☐ YES ☐ NO

History reviewed. ☐ No Changes. ☐ Additions as noted above.

Physician's Signature: _____ Date: _____