

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Male/Female

Optometrist \_\_\_\_\_ City \_\_\_\_\_

## PATIENT MEDICAL HISTORY FORM

Knowledge of your current and past medical problems is very helpful to the doctor. Your answers to the following questions will help us give you the best care. Please indicate by a check mark or by filling in the blanks, your answers to the following questions. If you do not know the answer, simply insert a question mark. Please print.

What problems are you having with your eyes? \_\_\_\_\_

Are you having trouble with any of the following? (Check all that apply.)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> driving at night  | <input type="checkbox"/> parking           | <input type="checkbox"/> difficulty reading medication bottles or small print |
| <input type="checkbox"/> glare from headlights   | <input type="checkbox"/> seeing road signs | <input type="checkbox"/> difficulty sewing                                    |
| <input type="checkbox"/> driving over the curb   | <input type="checkbox"/> recent accident   | <input type="checkbox"/> faces blurred  |
| <input type="checkbox"/> judging distances   | <input type="checkbox"/> stopped driving   | <input type="checkbox"/> film over your eye                                   |
| <input type="checkbox"/> difficulty with droopy lids or lumps or bumps around the eyes |  | <input type="checkbox"/> seeing the golf ball                                 |

Do you have glasses?  Yes  No For how long? \_\_\_\_\_ How long ago did you see your eye doctor? \_\_\_\_\_

Do you have contact lenses?  Yes  No If yes:  Soft  Disposable  Gas permeable

Do you use eye drops? What type? \_\_\_\_\_

Are you interested in speaking with a staff member about cosmetic or skin care products and services?  Yes  No

**For Infants and Children 15 or Younger:**

- Was child born premature?  Yes  No
- If so, how early? \_\_\_\_\_ Actual due date \_\_\_\_\_
- Birth Weight? \_\_\_\_\_
- On Oxygen after birth?  Yes  No How long? \_\_\_\_\_
- List any developmental delays or genetic defects:  
 \_\_\_\_\_
- Down's Syndrome  Yes  No
- Any other pediatric disorders? \_\_\_\_\_
- Have you noticed any eye deviations?  Yes  No
- turning in  turning out
- At what age did you first notice this: \_\_\_\_\_
- Has the child been treated by patching in the past?  Yes  No
- Does the child see and function well at home/school?  Y  N

Have you ever had or still have:

- |                          |                          |                             |
|--------------------------|--------------------------|-----------------------------|
| Y                        | N                        |                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Amblyopia/Lazy Eye          |
| <input type="checkbox"/> | <input type="checkbox"/> | Cataract                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Dry Eye                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Keratoconus                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Corneal Abrasion            |
| <input type="checkbox"/> | <input type="checkbox"/> | Recurrent Erosion           |
| <input type="checkbox"/> | <input type="checkbox"/> | Herpes Eye Infections       |
| <input type="checkbox"/> | <input type="checkbox"/> | Cornea Infection/Ulcer/Scar |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergic Conjunctivitis     |
| <input type="checkbox"/> | <input type="checkbox"/> | Trauma                      |

**Office Use Only**

Reviewed by:

\_\_\_\_\_  
 \_\_\_\_\_

**2-SIDED FORM**

## PATIENT MEDICAL HISTORY

Please list your **food and drug allergies**:

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### MEDICATIONS

Please list your current medications and how often you take them (include daily use of aspirin, NSAID, Coumadin, Plavix, ginkgo biloba, vitamin E, other anticoagulants, vitamins, minerals, over the counter medications and eye drops):

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Please list all previous operations (including eye surgery or eye laser surgery). Include complications of anesthesia or surgery and year done.

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Have you ever had or do you still have:

Y N	Y N
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Cancer-Type _____
<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> MRSA (Staph Infections)
<input type="checkbox"/> <input type="checkbox"/> COPD	<input type="checkbox"/> <input type="checkbox"/> Arthritis
<input type="checkbox"/> <input type="checkbox"/> Other Lung Problems	<input type="checkbox"/> <input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Epilepsy
Diagnosed When? _____	<input type="checkbox"/> <input type="checkbox"/> Polio
<input type="checkbox"/> <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> <input type="checkbox"/> Paralysis
<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> <input type="checkbox"/> Heart Attack	<input type="checkbox"/> <input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> <input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> <input type="checkbox"/> Alzheimer's/Dementia
<input type="checkbox"/> <input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> <input type="checkbox"/> Anemia/Bleeding Disorders
<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/> Type I Diabetes (Juvenile)
<input type="checkbox"/> <input type="checkbox"/> Circulation Problems	<input type="checkbox"/> <input type="checkbox"/> Type II Diabetes
<input type="checkbox"/> <input type="checkbox"/> Kidney Infections	Diagnosed When?
<input type="checkbox"/> <input type="checkbox"/> Kidney Stones	<input type="checkbox"/> <input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> <input type="checkbox"/> Kidney Failure	<input type="checkbox"/> <input type="checkbox"/> Steroid Use (prednisone)
<input type="checkbox"/> <input type="checkbox"/> Other Kidney, Bladder or	<input type="checkbox"/> <input type="checkbox"/> Abnormal Scarring/Healing
Prostate Problems	<input type="checkbox"/> <input type="checkbox"/> Problems with Anesthesia
<input type="checkbox"/> <input type="checkbox"/> Hepatitis	<input type="checkbox"/> <input type="checkbox"/> Are you pregnant or trying
<input type="checkbox"/> <input type="checkbox"/> Cirrhosis	to get pregnant?
<input type="checkbox"/> <input type="checkbox"/> Other Liver Diseases	<input type="checkbox"/> <input type="checkbox"/> Are you taking fertility meds?
<input type="checkbox"/> <input type="checkbox"/> Ulcers	<input type="checkbox"/> <input type="checkbox"/> Gone through menopause?
<input type="checkbox"/> <input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> <input type="checkbox"/> Other _____
<input type="checkbox"/> <input type="checkbox"/> Diverticulitis	Social History
<input type="checkbox"/> <input type="checkbox"/> Autoimmune Disorder	<input type="checkbox"/> <input type="checkbox"/> Use/Did Use tobacco
<input type="checkbox"/> <input type="checkbox"/> Lupus	<input type="checkbox"/> <input type="checkbox"/> Use/Did Use alcohol
<input type="checkbox"/> <input type="checkbox"/> HIV Positive	<input type="checkbox"/> <input type="checkbox"/> Use/Did Use other substances

**Family History-** Have any of your *blood* relatives had:

Y N	Y N	Y N
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Blindness
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Macular Degeneration	
<input type="checkbox"/> <input type="checkbox"/> Heart Problems	<input type="checkbox"/> <input type="checkbox"/> Crossing/Lazy Eye	