Hauser-Ross EYE INSTITUTE
PARTNER WITH VZN EYE CARE

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.)

☐ driving at night ☐ parking ☐ difficulty reading medication bottles or small print

☐ glare from headlights ☐ seeing road signs ☐ difficulty sewing ☐ recent falls

☐ driving over the curb ☐ recent accident ☐ faces blurred ☐ difficulty seeing colors

☐ judging distances ☐ stopped driving ☐ film over your eye ☐ seeing the golf ball

☐ difficulty with droopy lids or lumps or bumps around the eyes

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	
☐	☐	Amblyopia/Lazy Eye
☐	☐	Cataract
☐	☐	Glaucoma
☐	☐	Dry Eye
☐	☐	Keratoconus
☐	☐	Corneal Abrasion
☐	☐	Recurrent Erosion
☐	☐	Herpes Eye Infections
☐	☐	Cornea Infection/Ulcer/Scar
☐	☐	Allergic Conjunctivitis
☐	☐	Trauma

Office Use Only Reviewed by:

_____ _____ _____ _____

_____ _____ _____ _____

2-SIDED FORM

PATIENT MEDICAL HISTORY

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

_____
_____
_____

MEDICATIONS

Please list your current medications and how often you take them (include daily use of aspirin, NSAID, Coumadin, Plavix, gingko 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.

_____
_____
_____
_____
_____

Have you ever had or do you still have:

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

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

Y	N		Y	N		Y	N	
☐	☐	Cancer	☐	☐	Glaucoma	☐	☐	Blindness
☐	☐	Diabetes	☐	☐	Macular Degeneration			
☐	☐	Heart Problems	☐	☐	Crossing/Lazy Eye			