Medical History

Name of Primary Care Physician _____ Specialty Physician _____

Allergies: List all known medical allergies and environmental allergies

_____

Medications: Please list below (or provide a list of) all medications, including eye drops, nonprescription drugs, vitamins, herbal supplements. Please include dosage of all medications prescribed or over the counter.

_____

_____

Do you currently have any of the following problems?	Yes	NO	If yes, please explain
Ear/Nose/Throat problems (hearing loss, sinus problems, sore throat)	☐	☐	_____
Neurological Problems (numbness, weakness, headaches, paralysis)	☐	☐	_____
Psychiatric Problems (depression, anxiety)	☐	☐	_____
Cardiovascular Problems (heart disease, high blood pressure, heart arrhythmia)	☐	☐	_____
Respiratory (asthma, bronchitis, shortness of breath)	☐	☐	_____
Gastrointestinal Problems (heartburn, abdominal pain, diarrhea)	☐	☐	_____
Urinary Problems (pain or discomfort, blood in urine)	☐	☐	_____
Musculoskeletal Problems (muscle aches, joint pain, arthritis)	☐	☐	_____
Skin Problems (rashes, excessive dryness, rosacea)	☐	☐	_____
Endocrine (diabetes, thyroid problems)	☐	☐	_____
Hematologic/Lymphatic (anemia, bleeding problems)	☐	☐	_____
Allergy/Immunologic (environmental allergies, immune-compromising diseases)	☐	☐	_____

Do you currently have any of these eye related symptoms?

	Yes	NO	
Blurred Vision	☐	☐	
Double Vision	☐	☐	
Dry, Itchy, Red or Burning Eyes	☐	☐	
Mucous Discharge	☐	☐	
Sandy Gritty Feeling	☐	☐	
Foreign Body Sensation	☐	☐	
Excess Tearing/Watering		☐	☐
Glare/Light Sensitivity	☐	☐	
Eye Pain/Soreness		☐	☐
Chronic Infection of Eye/Lid	☐	☐	
Stye/Chalazion	☐	☐	
Flashes/Floaters in Vision		☐	☐

Have your immediate family members (parents, siblings, grandparents) have any of the following conditions?

	None	Relationship
Cataracts	☐	_____
Glaucoma	☐	_____
Eye Injury	☐	_____
Crossed/Lazy Eye	☐	_____
Retinal Detachment	☐	_____
Retinal Degeneration	☐	_____
Macular Degeneration	☐	_____
Blindness	☐	_____
Diabetes (type 1 or 2)	☐	_____
Hypertension	☐	_____
Hyperthyroidism	☐	_____
Hypothyroidism	☐	_____
Cancer	☐	

_____

Surgeries: List any previous surgeries, including eye surgeries and laser procedures.

_____

Height _____ Weight _____ Are you pregnant/nursing? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No Frequency _____

Do you currently smoke? ☐ Yes ☐ No If yes, how much? _____ How long have you been smoking?

_____

If no, have you previously been a smoker? ☐Yes ☐No

Patient or Guardian Signature _____ Date _____