MEDICAL HISTORY RECORD

Please complete the form. Do not leave anything blank.

Patient's Name (Last, First): _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone Number: _____

Date of Last Eye Exam: _____ Previous Eye Doctor: _____

Primary Care Physician: _____ Phone #: _____

WHAT DO YOU WEAR?

☐ Glasses: Distance / Near / Multifocal ☐ Contacts (Brand): _____ ☐ None/ 1st Exam

DO YOU EXPERIENCE ANY OF THE FOLLOWING SYMPTOMS?

☐ Dry Eyes or Pain: Right Eye / Left Eye / Both Eyes ☐ Blurred Vision: Distance / Near / Both

☐ Floaters _____ ☐ Flashes of Light _____

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No How much? _____

Do you drink alcohol? ☐ Yes ☐ No How much? _____

Do you use other substances? ☐ Yes ☐ No What and how much? _____

PERSONAL MEDICAL HISTORY

Are you allergic to any medications or other substances? ☐ Yes. _____ ☐ No

Are you currently taking any medications (prescription / OTC, artificial tears/ eye drops, vitamins)? ☐ Yes ☐ No

If yes, please list medications and their usage. _____

_____

Ladies, are you pregnant or breastfeeding at this time? ☐ Yes ☐ No

Have you been diagnosed with any of the following? Please *check* all that apply & write the *diagnosis* *date* next to each condition.

☐ Healthy	☐ Surgeries (what types & when): _____		
Ocular:	☐ Cataract	☐ Glaucoma	☐ Macular Deg.
	☐ Eye Injury	☐ Eye Surgery	☐ Lazy Eye
Cardiovascular:	☐ High Cholesterol	☐ Hypertension	☐ Stroke
Endocrine:	☐ Diabetes	☐ Thyroid	☐ Liver
Neurology:	☐ Headaches	☐ Multiple Sclerosis	☐ Seizures
Immunology:	☐ Arthritis	☐ Lupus	
Skin Disorders:	☐ Rosacea	☐ Eczema	
Respiratory:	☐ Asthma	☐ Allergy	☐ Bronchitis
Blood/Lymphatic:	☐ Bleeding Disorder	☐ Cancer	
Psychiatric:	☐ Insomnia	☐ Depression	☐ Anxiety
Constitutional:	☐ Fever/Chills	☐ Weight Gain	☐ Weight Loss
Genitourinary:	☐ Kidneys	☐ Bladder	
Gastrointestinal:	☐ Diarrhea	☐ Constipation	

FAMILY MEDICAL HISTORY - Please *check* all that apply to your *blood relatives* & write the *relationship* next to each condition.

☐ Diabetes	☐ Glaucoma	☐ Macular Deg.	☐ None
☐ Hypertension	☐ Cataracts	☐ Retinal Detachment	

DILATION REFUSAL

It is highly recommended to have your pupils dilated in order for the doctor to evaluate the internal ocular health of your eyes to rule out common eye conditions such as cataract, glaucoma, macular degeneration, and other eye diseases. Your vision might be blurry up to 6 hours, especially close up. Your eyes will also be very sensitive to light and outdoors. Most people can drive home with their sunglasses or the provided disposable shade after dilation. If your are unsure, you may bring a driver and reschedule for your next appointment. Please sign below if you refuse to have your eyes dilated today.

Signature: _____ Date: _____

Please also sign below that you have reviewed all the information above and it is correct to the best of your knowledge.

Signature: _____ Date: _____