Medical History Record

Appointment Date_____/_____/_____

Patient Name (First M.I Last) | Birth Date / / | M or F

Race: Caucasian African American Hispanic Asian (Circle)

Occupation | Hobbies

Emergency Contact | Phone Number - -

Previous Eye Doctor | Last exam Date / /

Name of Family Doctor | Approx. Date of Last Visit / /

Phone Number - -

MEDICAL HISTORY - Personal

YES NO

[ ] [ ] Are you taking any medication, vitamins, oral contraceptives, aspirin, OTC meds?
[ ] [ ] Do you have any medication allergies?
[ ] [ ] Have you had any major surgeries or hospitalization? List
[ ] [ ] Are you pregnant or nursing?
[ ] [ ] Do you wear glasses?
[ ] [ ] Do you wear contact lenses?
[ ] [ ] Do you have any history of [ ]eye muscle problem, [ ]Lazy eye, [ ]Eye Injury, [ ]Dry Eye [ ]Glaucoma, [ ]Cataract, [ ]Retinal Disease, [ ]Eye Surgery, [ ]Eye Infection

FAMILY HISTORY of parents, grandparents, siblings

YES	NO		YES	NO		YES	NO	
[ ]	[ ]	Glaucoma	[ ]	[ ]	Cataract	[ ]	[ ]	High BP
[ ]	[ ]	Macular Degeneration	[ ]	[ ]	Blindness	[ ]	[ ]	Heart Disease
[ ]	[ ]	Retinal Detachment	[ ]	[ ]	Diabetes	[ ]	[ ]	Thyroid Disease
						[ ]	[ ]	Other_____

SOCIAL HISTORY

YES NO

[ ] [ ] Vision difficulty while driving
[ ] [ ] Do you use alcohol?
[ ] [ ] Do you use tobacco products?

Yes NO

[ ] [ ] Do you use illegal drugs?
[ ] [ ] Have you been infected with [ ] Hepatitis, [ ]HIV, [ ]Venereal Disease

REVIEW OF SYSTEMS - Personal

YES	NO		YES	NO		YES	NO	
		EYES			**CONSTITUTIONAL**			**NEUROLOGIC**
[ ]	[ ]	Blurred Vision	[ ]	[ ]	Fever, Weight Change	[ ]	[ ]	Headaches
[ ]	[ ]	Loss of Vision			EARS, NOSE, MOUTH	[ ]	[ ]	Migraines
[ ]	[ ]	*Double Vision*	[ ]	[ ]	*Allergies, Hay fever*	[ ]	[ ]	*Seizures*
[ ]	[ ]	Dry Eyes	[ ]	[ ]	Dry Mouth, Nasal Drip			**ENDOCRINE**
[ ]	[ ]	Red, Sandy, Itch, Tearing			**Lymph/Hematologic**	[ ]	[ ]	Thyroid disease
[ ]	[ ]	Lid or Sty Infection	[ ]	[ ]	Anemia, Bleeding	[ ]	[ ]	Diabetes (Yr. diagnosed_____)
[ ]	[ ]	Flashes or Floaters			**VASCULAR/CARDIO**			**RESPIRATORY**
		BONES/JOINT/MUCSLES	[ ]	[ ]	Heart Attack	[ ]	[ ]	Asthma
[ ]	[ ]	Rheumatoid Arthritis	[ ]	[ ]	High Blood Pressure	[ ]	[ ]	Emphysema, Chronic Bronchitis
[ ]	[ ]	Muscle or Joint Pain	[ ]	[ ]	Elevated Cholesterol			**PSYCHIATRIC**
		INTEGUMENTARY	[ ]	[ ]	Atherosclerosis	[ ]	[ ]	Depression/Anxiety
[ ]	[ ]	Skin, Rosacea			**ALLERGIC/IMMUNILOG**			**GASTROINTESTINAL**
		GENITOURINARY	[ ]	[ ]	Sinus Congestion	[ ]	[ ]	Ulcer, Colitis
[ ]	[ ]	Kidney/Bladder	[ ]	[ ]	HIV	[ ]	[ ]	Hepatitis

I have reviewed my Medical History Record and there are no changes.

Date: - - Signature:_____

Date: - - Signature:_____

Date: - - Signature:_____

Date: - - Signature:_____