MEDICAL HISTORY FORM

Patient Name: ____**Today's Date:** _____________________

The information in this confidential personal history form is critical to the evaluation of your visual system.

Family Physician's Name: ______________________________________ **Date of last visit:** ________________________

Reason for today's visit: ____________________________________

Are you interested in purchasing new glasses today? Yes . . . .No

Are you interested in contact lenses? Yes . . . No

Review of Systems: Please indicate any current or past PERSONAL history below: Check √ all that apply

Constitutional

___Good general health lately
___Developmental disability
___Cancer (Type:____________)

Ears/Nose/Mouth/Throat

___Sinusitis
___Dry mouth or throat

Neurological

___Multiple Sclerosis (MS)
___Tumor
___Migraine

Psychiatric

___Depression
___Attention deficit (ADD)

Cardiovascular

___Heart Disease
___Hypertension/Blood pressure
___Stroke/CVA

Respiratory

___COPD (chronic obstruction)
___Sleep Apnea
___Asthma

Gastrointestinal

___Crohn's

Genitourinary

___BPH(prostate)
___Currently pregnant
___Currently nursing

Integumentary

___Herpes simplex/cold sores
___Rosacea
___Herpes zoster/shingles

Endocrine

___Type 2 Diabetes
___Type 1 Diabetes
___Thyroid dysfunction

Hematologic/Lymphatic

___High Cholesterol
___Anemia

Allergy/Immune

___Rheumatoid Arthritis
___Sjogrens Syndrome

Past Ocular History

___Cataract
___Macular degeneration
___Eye surgery
___Patching
___Stabismus(turned eye)
___Amblyopia(lazy eye)
___Dry eye
___Injury
___Glaucoma suspect
___Glaucoma

List Allergies (Both drug and environmental)____

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Smoking Status: Please Check √ the most appropriate response

___Never Smoker
___Previous Smoker
___Current smoker occasional
___Current smoker every day

List Medications You Are Taking (Include Non-prescription)____

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Please indicate FAMILY history: Circle Yes or No; If Yes, write in father, mother, brother, sister, son or daughter

☐ **Medical**

Cancer . . . . No Yes______________________
Diabetes . . . . No Yes______________________
Hypertension. . . . . . No Yes______________________

☐ **Ocular**

Cataract . . . . No Yes___________________________
Macular degeneration . . No Yes___________________________
Glaucoma . . . . No Yes___________________________