Medical History

Patient name_____ DOB_____ Date_____

Last Eye Doctor_____ Current Medical Doctor_____

Last Eye Exam_____ Last Medical Exam_____

List any medication allergies_____

_____

List current medications_____

_____

List any major injuries, surgeries, or hospitalizations_____

_____

Are you pregnant or nursing _____ Do you use: glasses_____ contact lenses_____

Do you smoke, drink, or use recreational substances _____ If so, type/amt/duration

_____

Have you been exposed to any sexually transmitted diseases _____

Do any of the following eye conditions affect you or a biological family member?

If yes, indicate either self (S) or family member (FM).

Crossed eyes_____ Lazy eye_____ Glaucoma_____ Retinal det/disease_____

Cataracts_____ Eye injury_____ Blindness_____ Macular deg._____

Circle any of the eye conditions that affect **you**.

Blurred vision	Loss of vision	Distorted vision	Double vision
Peripheral vision loss	Dryness	Discharge	Redness
Sandy/Gritty eyes	Itchy	Color Blindness	Excess tears
Eye pain	Eye infection	Sties/Chalazion	Flashes/Floaters

Do any of the following medical conditions affect you or a biological family member?
Indicate either self (S) or family member (FM).

Arthritis_____	Cancer_____	Diabetes_____	Heart disease_____	Thyroid____
Hypertension____	Kidney disease___	Headaches_____	Psychiatric_____	Allergies___
Asthma_____	Bronchitis_____	Emphysema_____	Vascular disease_____	Anemia____
Cholesterol_____	Bleeding_____	GI tract_____	Seizures_____	Stroke_____