PATIENT'S MEDICAL HISTORY FORM

Do you suffer from or have been treated for any of the following? (Please check any that pertain to you)

- ☐ Blurred Vision, Distance
- ☐ Blurred Vision, Near
- ☐ Blurred Vision, Night
- ☐ Blurred Vision, Computer Distance
- ☐ Contact lens discomfort
- ☐ Light Sensitivity
- ☐ Eye Strain/Fatigue
- ☐ Double Vision
- ☐ Itchiness
- ☐ Grittiness/Scratchy
- ☐ Dryness
- ☐ Redness
- ☐ Tearing/Watering eye(s)
- ☐ Burning
- ☐ Discharge
- ☐ Vision or Field of Vision Loss
- ☐ Flashes of Light
- ☐ Floaters/Spots
- ☐ Halos
- ☐ Crossed eye/Turned eye
- ☐ Eye Infections
- ☐ Bump on Eye Lid(s)
- ☐ Headaches/Migraines
- ☐ Ocular Allergies
- ☐ Corneal Abrasions
- ☐ Eye Injury
- ☐ Iritis/Uveitis
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Color Deficiency
- ☐ Diabetic Retinopathy
- ☐ Keratoconus
- ☐ Eye Surgeries
- ☐ Other:______________________

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation(Irregular Heartbeat)
- ☐ Bone Marrow Transplantation
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Stroke
- ☐ Other:______________________

Are you using eye drops? Y___ N ___ If yes, what type? ________________________ How often? __________________

Please list all Prescribed and Over the Counter Medications, including Eye Drops, vitamins and supplements, you are currently taking (if you have a list please give it to the receptionist to make a copy)

Name of Prescription/Medication	Taken for what Condition	Dosage	Frequency

Please list all Medications you are Allergic to:

Name of Medication	Reaction	Name of Medication	Reaction

Is there a Family Medical History of any of the following?

	Relationship		Relationship		Relationship
☐ High Blood Pressure	_____________	☐ Glaucoma	___________	☐ Heart Disease	____________
☐ Diabetes	_____________	☐ Cataracts	___________	☐ Retinal Problems	____________
☐ Cancer	_____________	☐ Macular Degeneration	___________	☐ Corneal Problems	____________

Primary Care Provider (PCP) _________________________________ **Referring Provider** _________________________________

Social History: Use of Tobacco/Alcohol

Are you currently a smoker? Yes___ No___ Have you been a smoker in the past? Yes___ No___

Do you drink Alcohol? Yes___ No___ If so, how many glasses a day? _____