

Medical History

Name Age Exam Date

When was your last health exam?

When was your last eye exam?

Drug Allergies Yes No

If yes, list the medications :

Referring Doctor

| | | | |
|---------|------------------------------------------|------------------------------------------|------------------------------------------|
| ID | <input style="width: 95%;" type="text"/> | Title | <input style="width: 50%;" type="text"/> |
| Name | <input style="width: 95%;" type="text"/> | | |
| Clinic | <input style="width: 95%;" type="text"/> | | |
| Address | <input style="width: 95%;" type="text"/> | | |
| Phone | <input style="width: 45%;" type="text"/> | <input style="width: 45%;" type="text"/> | <input style="width: 10%;" type="text"/> |

Primary Care Physician

| | | | |
|---------|------------------------------------------|------------------------------------------|------------------------------------------|
| ID | <input style="width: 95%;" type="text"/> | Title | <input style="width: 50%;" type="text"/> |
| Name | <input style="width: 95%;" type="text"/> | | |
| Clinic | <input style="width: 95%;" type="text"/> | | |
| Address | <input style="width: 95%;" type="text"/> | | |
| Phone | <input style="width: 45%;" type="text"/> | <input style="width: 45%;" type="text"/> | <input style="width: 10%;" type="text"/> |

Current Eye Symptoms

Comments/Description of Symptoms

| | | |
|---------------------------|----------------------------------------------------|------------------------------------------|
| Glaucoma | <input type="radio"/> Yes <input type="radio"/> No | <input style="width: 95%;" type="text"/> |
| Cataract | <input type="radio"/> Yes <input type="radio"/> No | <input style="width: 95%;" type="text"/> |
| Macular degeneration | <input type="radio"/> Yes <input type="radio"/> No | <input style="width: 95%;" type="text"/> |
| Retinal Detachment | <input type="radio"/> Yes <input type="radio"/> No | <input style="width: 95%;" type="text"/> |
| Color Blindness | <input type="radio"/> Yes <input type="radio"/> No | <input style="width: 95%;" type="text"/> |
| Asthenopic | | |
| Headaches | <input type="radio"/> Yes <input type="radio"/> No | <input style="width: 95%;" type="text"/> |
| Glare/Light Sensitivity | <input type="radio"/> Yes <input type="radio"/> No | <input style="width: 95%;" type="text"/> |
| Tired Eyes | <input type="radio"/> Yes <input type="radio"/> No | <input style="width: 95%;" type="text"/> |
| Physiologic | | |
| Amblyopia (Lazy Eye) | <input type="radio"/> Yes <input type="radio"/> No | <input style="width: 95%;" type="text"/> |
| Strabismus (Crossed Eyes) | <input type="radio"/> Yes <input type="radio"/> No | <input style="width: 95%;" type="text"/> |
| Dryness | <input type="radio"/> Yes <input type="radio"/> No | <input style="width: 95%;" type="text"/> |
| Visual Symptoms | | |
| Blurred Vision Distance | <input type="radio"/> Yes <input type="radio"/> No | <input style="width: 95%;" type="text"/> |
| Blurred Vision Near | <input type="radio"/> Yes <input type="radio"/> No | <input style="width: 95%;" type="text"/> |
| Double Vision | <input type="radio"/> Yes <input type="radio"/> No | <input style="width: 95%;" type="text"/> |
| Floater or Spots | <input type="radio"/> Yes <input type="radio"/> No | <input style="width: 95%;" type="text"/> |
| Loss of Vision | <input type="radio"/> Yes <input type="radio"/> No | <input style="width: 95%;" type="text"/> |
| Loss of Side Vision | <input type="radio"/> Yes <input type="radio"/> No | <input style="width: 95%;" type="text"/> |
| Other | <input type="radio"/> Yes <input type="radio"/> No | <input style="width: 95%;" type="text"/> |

Review of Systems

Specify Condition and when Diagnosed

Cancer: Yes No

Medical History - Main Exam

Musculo-Skeletal:

| | | | |
|------------------------|---------------------------|--------------------------|--|
| Degenerative Arthritis | <input type="radio"/> Yes | <input type="radio"/> No | |
| Rheumatoid Arthritis | <input type="radio"/> Yes | <input type="radio"/> No | |
| Lupus or Other | <input type="radio"/> Yes | <input type="radio"/> No | |

Lungs:

| | | | |
|--------------------------|---------------------------|--------------------------|--|
| Asthma/Emphysema | <input type="radio"/> Yes | <input type="radio"/> No | |
| Tuberculosis/Sarcoidosis | <input type="radio"/> Yes | <input type="radio"/> No | |
| Environmental Allergies | <input type="radio"/> Yes | <input type="radio"/> No | |

Heart:

| | | | |
|--------------------------|---------------------------|--------------------------|--|
| Heart Attack(s) | <input type="radio"/> Yes | <input type="radio"/> No | |
| Congestive heart failure | <input type="radio"/> Yes | <input type="radio"/> No | |
| Coronary artery disease | <input type="radio"/> Yes | <input type="radio"/> No | |
| Carotid artery disease | <input type="radio"/> Yes | <input type="radio"/> No | |
| Irregular Heartbeat | <input type="radio"/> Yes | <input type="radio"/> No | |

Blood:

| | | | |
|--------------------------|---------------------------|--------------------------|--|
| High Blood Pressure | <input type="radio"/> Yes | <input type="radio"/> No | |
| Low Blood Pressure | <input type="radio"/> Yes | <input type="radio"/> No | |
| Elevated Cholesterol | <input type="radio"/> Yes | <input type="radio"/> No | |
| Anemia/bleeding disorder | <input type="radio"/> Yes | <input type="radio"/> No | |
| Sickle Cell or Other | <input type="radio"/> Yes | <input type="radio"/> No | |

Endocrine:

| | | | |
|----------|---------------------------|--------------------------|--|
| Diabetes | <input type="radio"/> Yes | <input type="radio"/> No | |
| Thyroid | <input type="radio"/> Yes | <input type="radio"/> No | |
| Other | <input type="radio"/> Yes | <input type="radio"/> No | |

Gastrointestinal:

| | | | |
|--------------------|---------------------------|--------------------------|--|
| Hepatitis/Jaundice | <input type="radio"/> Yes | <input type="radio"/> No | |
| Ulcers/Bleeding | <input type="radio"/> Yes | <input type="radio"/> No | |

Nervous/Psychiatric:

| | | | |
|----------------------|---------------------------|--------------------------|--|
| Stroke/Paralysis/TIA | <input type="radio"/> Yes | <input type="radio"/> No | |
| Migraine Headaches | <input type="radio"/> Yes | <input type="radio"/> No | |
| Alzheimer's/Dementia | <input type="radio"/> Yes | <input type="radio"/> No | |
| Depression | <input type="radio"/> Yes | <input type="radio"/> No | |
| Seizures/MS/Other | <input type="radio"/> Yes | <input type="radio"/> No | |

Genitourinary:

| | | | |
|-------------------------------|--------------------------------------------------------------------|--------------------------|--|
| Kidney Disease | <input type="radio"/> Yes | <input type="radio"/> No | |
| Currently Pregnant or Nursing | <input type="checkbox"/> Pregnant <input type="checkbox"/> Nursing | | |

List Prior Eye Surgeries, including laser:

Which Eye and Date of surgery:

| | |
|--|--|
| | |
| | |
| | |

List all Medications (prescribed or over-the-counter) that you take:

| Name | Taken for what Condition |
|------|--------------------------|
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Medical History -

| Eye Drops: | Frequency: | Which Eye? |
|------------|------------|------------|
| | | |
| | | |
| | | |
| | | |

| Family History | Relationship to Patient |
|-------------------------------------------------------------------------|-------------------------|
| Lazy Eye/Eye Turn <input type="radio"/> Yes <input type="radio"/> No | |
| Blindness <input type="radio"/> Yes <input type="radio"/> No | |
| Glaucoma <input type="radio"/> Yes <input type="radio"/> No | |
| Macular Degeneration <input type="radio"/> Yes <input type="radio"/> No | |
| Retinal Detachment <input type="radio"/> Yes <input type="radio"/> No | |
| Diabetes <input type="radio"/> Yes <input type="radio"/> No | |
| Heart Disease <input type="radio"/> Yes <input type="radio"/> No | |
| Other <input type="radio"/> Yes <input type="radio"/> No | |

Social History

Current Occupation: Occupation Employer

Do you drink alcohol? No Occasional 1 per day 2-3/day 4+/day

Do you smoke? No Occasional 1/2 pack/day 1 pack/day 1+ pack

Special Eyewear Needs? Computer (special prescriptions, special anti-glare tints or coatings) Other...
 Occupational (mechanics, plumbers, pilots)
 Safety Glasses (gardening, woodworking, welding)
 Sports/Hobbies (racquet sports, motorcycle)

Contact Lenses: There are additional fees for contact lens services.

Do you currently wear, or are you interested in contact lenses? Yes No

If you previously wore contacts, what was the reason for stopping?

Current lens wear:

How many hours/day? How many days/week?

Do you sleep in your lenses? Yes No

How frequently do you replace your lenses?

Vision with my current lenses is: Good Okay Poor

History Reviewed Aug 18, 2010