Patient Name: DOB: Date:

PATIENT MEDICAL INFORMATION

Many medical conditions and medications affect the eyes. Please help the doctor by filling out your medical history as completely as possible.
Please check all of the conditions that apply to you:

Respiratory Issues	☐ Yes	☐ No	**Hematologic Conditions**	☐ Yes	☐ No	**Ear/Nose/Throat Problems**	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Sickle Cell	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Dental Problems	☐ Yes	☐ No
Skin Conditions	☐ Yes	☐ No	**Allergy/Immunology**	☐ Yes	☐ No	**Neurological Disorder**	☐ Yes	☐ No
Eczema	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No
Rosacea	☐ Yes	☐ No	Sjogren's Syndrome	☐ Yes	☐ No	Multiple Headaches	☐ Yes	☐ No
Endocrine Disorder	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Lupus	☐ Yes	☐ No	Myasthenia Gravis	☐ Yes	☐ No
Thyroid Disorder	☐ Yes	☐ No	**Fever/Fatigue/Weight Loss**	☐ Yes	☐ No	Head Injury	☐ Yes	☐ No
Gastrointestinal Issues	☐ Yes	☐ No	**Musculoskeletal Conditions**	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	**Kidney/Bladder Problems**	☐ Yes	☐ No
Cardiovascular Conditions	☐ Yes	☐ No	**Psychiatric Disorder**	☐ Yes	☐ No	**Sexually Transmitted Diseases**	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No	**Cancer**	☐ Yes	☐ No
Heart Failure	☐ Yes	☐ No	Depression	☐ Yes	☐ No	**Surgical Operations**	☐ Yes	☐ No

Have you previously had any eye injuries, eye surgeries or eye diseases? ☐ Yes ☐ No If yes, please describe:

Have you experienced any floaters, flashes of light, burning, itching, redness, dryness, double vision, unusual blurry vision, frequent styes/chalazions, or excessive tearing/watering? ☐ Yes ☐ No If yes, please describe:

Do you have light sensitivity or issues with glare while outdoors or driving? ☐ Yes ☐ No ☐ Sometimes
Do you have issues with glare or have eye fatigue while on a computer? ☐ Yes ☐ No ☐ Sometimes

Are you currently being treated for any other medical conditions? ☐ Yes ☐ No If yes, please describe:

Please list any medications you are currently taking *(Including hormones, vitamins, birth control, aspirin, other anti-inflammatory, eye drops, etc.)* : ☐ None

Date of last general health exam: _____ Date of last eye exam: _____ Previous eye care provider: _____

Are you currently pregnant or nursing? ☐ Yes ☐ No
Do you smoke or use tobacco? ☐ Yes ☐ No ___Less than 1 Pack a Day ___1-2 Packs a Day ___2 Packs a Day
Do you drink alcohol? ☐ Yes ☐ No ___Social ___1-2 Drinks Daily ___Above Average Use ___Dependence
Are you allergic to any medications? ☐ Yes ☐ No If yes, please list: _____

CONTACT LENS INFORMATION

Do you currently wear contact lenses? ☐ Yes ☐ No If yes, please list the brand: _____

How many hours a day do you wear contacts? _____ How often do you throw away your lenses? _____

Do your eyes feel dry while wearing contacts? ☐ Yes ☐ No What do you use to clean your lenses?_____

FAMILY HISTORY

Has anyone in your family had any of the following illnesses?

Blindness*	☐ Yes	☐ No	Relationship: _____
Cancer*	☐ Yes	☐ No	Relationship: _____
Cataract	☐ Yes	☐ No	Relationship: _____
Color Blindness*	☐ Yes	☐ No	Relationship: _____
Diabetes*	☐ Yes	☐ No	Relationship: _____
Glaucoma*	☐ Yes	☐ No	Relationship: _____
Heart Disease	☐ Yes	☐ No	Relationship: _____
High Blood Pressure*	☐ Yes	☐ No	Relationship: _____
Lazy Eye*	☐ Yes	☐ No	Relationship: _____
Macular Degeneration*	☐ Yes	☐ No	Relationship: _____
Respiratory Disease	☐ Yes	☐ No	Relationship: _____
Retinal Detachment*	☐ Yes	☐ No	Relationship: _____

**Additional testing may be covered through your medical insurance.*

For Office Use Only

L	FDT	PHOTO
A	O	