Medical History Form

Today's Date:_____Name:_____

Date of last eye exam:_____Primary Care Physician:_____

Do you currently wear glasses or contacts? **Y N** How old are your current glasses?_____

Are you currently pregnant or nursing? **Y N**

Please list all medications that you are allergic to, the reaction you had and the year it occurred:

_____
_____
_____

Please list ALL current medications you are taking:

_____
_____
_____
_____

Please list ALL major surgeries you have had:

_____
_____

Social History

(This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.)

Do you drive? **Y N** If yes, do you have difficulty while driving?_____

Have you ever been exposed to or infected with HIV or any Sexually Transmitted Disease? **Y N**

If YES please explain:_____

Do you use tobacco products? Y N If yes, list the type, amount and frequency_____

Do you drink alcohol? Y N if yes, list the type, amount and frequency_____

Do you use illegal drugs? Y N if yes, list the type, amount and frequency_____

Patient Ocular/Medical History

Please circle if you currently have or ever have had any problems with:

Headaches	Thyroid/Other Glands
Blurred Vision	Allergies
Double Vision	Asthma
Dry Eye	Diabetes
Redness	High Blood Pressure
Itching	Kidney Disorder
Burning	Bladder Disorder
Watering	Arthritis
Eye Pain	Anemia
Stye	Cancer
Flashes	Floaters

Family Medical History (Family Members other than the Patient)

Please note any family history for the following conditions and the relationship to the patient:

Blindness: Y N _____

Cataracts: Y N _____

Crossed Eyes: Y N _____

Glaucoma: Y N _____

Macular Degeneration: Y N _____

Retinal Detachment: Y N _____

Arthritis: Y N _____

Cancer: Y N_____

Diabetes: Y N_____

High Blood Pressure: Y N _____

Kidney Disease: Y N _____

Thyroid Disease: Y N _____