Medical History Form

Name:___________________________________ Date:_________________________

Occupation:________________________________Do you wear glasses? Yes O No O Contacts? Yes O No O

Interested in Contacts? Yes O No O Interested in LASIK? Yes O No O Do you sleep in Contacts Yes O No O NA O

What brings you to our office today?____

Describe any eye problems you are having. When did this problem start? Is it getting worse? One eye or both?

____

____

Ocular History

Any history of eye problems such as eye-crossing, cataracts, macular degeneration, eye infections, glaucoma, retinal detachment, dry eyes, eye allergies, or any other eye conditions? Yes O No O If yes, please list the condition and describe when you had this problem. ____

____

Medical History

Any medical problems such as heart, lung, diabetes, high blood pressure, High cholesterol, Diabetes with insulin, Diabetes without taking insulin, Arthritis, Thyroid, Kidney, Cancer? Please list these are any other problems:__________________________________

__________ ____

Surgical History

Please list any surgeries and when you had them: ____

Family Medical History

Please list any medical problems such as diabetes, arthritis, cancer, high blood pressure, kidney disease, heart problems, thyroid disease, Lupus, etc. that any blood relatives have. ____

____

Ocular Surgical History

Have you had any eye surgery? Yes O No O If yes, list the surgery and which eye:

____

Ocular Family History

List any eye problems blood relatives have such as glaucoma, macular, retina, or any other:_____________________________

____

Ocular Medications

Please list any eye medications you take: ____

____

Systemic Medications

Please list any medications you take: ____

____

Review of Systems-Questions about your health

	yes	no		yes	no		yes	no
Allergy or Sinus			Endocrine			Depression		
Heart Disease			Diabetes			Anxiety		
Irregular heart beat			Thyroid			Bipolar		
High Blood Pressure			Genital-Urinary			Other mental illness		
Fever			Blood, lymph, and immune			Neurologic		
Weight loss/gain			Skin			Lung eg. asthma, emphysema,		
Ear,Nose,Throat, Mouth			Muscle, bones, joints			Allergy to any Medicine		

List any medications you are allergic to:____

Social History

Do you smoke? Yes O No O If yes, how many packs a day_____Former Smoker? Yes O No O

Do you drink alcohol? Yes O No O If yes, how often:____________ Height:_______Weight:_________

Do you use illegal drugs? Yes O No O

Have you been exposed to HIV? Yes O No O Have you been exposed or infected with Gonorrhea? Yes O No O

Have you been exposed to Hepatitis? Yes O No O Have you been exposed to or infected with Syphilis? Yes O No O