Medical History

Height: _____ Weight: _____ Blood Pressure (If known):_____

Race/ Ethnicity_____ Pulse (If known):_____

Medications:

☐ None Taken or List Below

Name	Dosage	Frequency	Reason for

Eye Medications:

☐ None Taken or List Below

Name	Dosage	Frequency	Reason for

Eye History:

Wear **Glasses** for (circle all that applies)? Nearsightedness Farsightedness Astigmatism Reading

Wear **Contacts** for (circle all that applies)? Nearsightedness Farsightedness Astigmatism Reading

☐ Glaucoma ☐ Lazy Eye ☐ Injury ☐ Macular Degeneration ☐ Cataract

List others below:

Eye Surgery, Event, or Disease	Right Eye	Left Eye	Date

Allergies: ☐ None Known ☐ Latex

Drugs: _____

Food: _____

Illnesses

☐ Diabetes ☐ Heart Disease ☐ Asthma ☐ High Blood Pressure ☐ Emphysema ☐ Stroke
☐ Cancer ☐ Arthritis ☐ COPD ☐ High Cholesterol ☐ CHF ☐ Sleep Apnea(C-Pap machine?)

Surgery

☐ Tonsils ☐ Appendectomy ☐ Heart ☐ Gallbladder ☐ None or *List Others*

_____

_____

Family History			**Relationship to Patient**				**Relationship to Patient**
	Y	**N**	**M**other **F**ather **S**ibling **G**randparent		**Y**	**N**	**M**other **F**ather **S**ibling **G**randparent
Blindness				Heart Disease			
Glaucoma				High B/P			
Arthritis				Kidney Disease			
Cancer				Lupus			
Diabetes				Stroke			
Cataract				Macular Degen.			

Review of Systems	**Y**	**N**	***If YES, Please Explain***
General/ Constitutional (fever, weight loss, obesity, etc.)			
Integumentary/ Skin (rashes, growths, hair loss, etc.)			
Neck (swollen glands, thyroid, etc.)			
Ears (hearing loss, drainage, etc.)			
Respiratory (congestion, wheezing, COPD, etc.)			
Cardiovascular (high B/P, racing pulse, etc.)			
Gastrointestinal (upset stomach, diarrhea, constipation, etc.)			
GenitoUrinary (painful or frequent urination, impotence, etc.)			
MusculoSkeletal (joint pain, stiffness, swelling, cramps, etc.)			
Neurological (seizures, convulsions, numbness, headache, weakness, etc)			
Endocrine (bruising, diabetes, hypothyroid, etc.)			
Hemato-Immunologic (anemia, high cholesterol, bleeding tendencies, etc)			
Psychiatric (anxiety, depression, insomnia, etc.)			

Do you drink alcohol? *If Yes*: ☐ occasionally ☐ 1/day ☐ 2-3/day ☐ 4+/day NO

Do you smoke? *If Yes*: ☐ occasionally ☐ ½ pack/day ☐ 1 pack/day ☐ 1+ packs/day NO