



MEDICAL HISTORY

Name _____
 Family Physician _____
 Date of Birth _____ Date of last eye exam _____

Review of Systems Please answer yes or no for each question

	Yes	No		Yes	No		Yes	No
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestine Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Increased Urination and/or Thirst	<input type="checkbox"/>	<input type="checkbox"/>
Rash	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Eyes								
Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Contacts	<input type="checkbox"/>	<input type="checkbox"/>	Refractive Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Halos	<input type="checkbox"/>	<input type="checkbox"/>	Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Tearing	<input type="checkbox"/>	<input type="checkbox"/>	Redness	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>
Flashes	<input type="checkbox"/>	<input type="checkbox"/>	Floaters	<input type="checkbox"/>	<input type="checkbox"/>	Protruding Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Glare	<input type="checkbox"/>	<input type="checkbox"/>				Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Other	_____							

Past Medical History

	Yes	No	
Eye disease	<input type="checkbox"/>	<input type="checkbox"/>	Describe _____
Eye surgery	<input type="checkbox"/>	<input type="checkbox"/>	Describe _____
Other surgery	<input type="checkbox"/>	<input type="checkbox"/>	Describe _____

	Yes	No		Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Seizure	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Bypass	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>				Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
						Irregular/Fast Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>
						Anemia or Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>
						Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any other medical problems			Yes	No				
Describe			<input type="checkbox"/>	<input type="checkbox"/>	_____			

Please list medications you are currently taking. (Including eye medications) _____

Are you allergic to any medications? Yes No
 Please list. _____

Family History Yes No
 Has anyone in your family (Parents, Sister, or Brother) had a serious eye problem?
 Explain _____

Social History Yes No
 Do you smoke?

Physician Signature _____ Date _____