MEDICAL HISTORY INFORMATION

Last Name | First Name | DOB | Age

Reason for visit today:

Past, Family & Social History (Please check ALL appropriate boxes)

Patient Past
- Eye Injury
- Glaucoma
- Cataract
- Macular Degeneration
- Surgery
- Hypertension
- Diabetic
- Cancer

Family History
- Glaucoma
- Cataract
- Macular Degeneration
- Surgery
- Hypertension
- Diabetic
- Cancer

Patient Social History
Smoke
- never
- in past
- current

Alcohol
Other

Occupational
Do you have any work related visual needs?

Yes No

if Yes please explain:

Do you have any of the following?: (Please check ALL appropriate boxes)

Allergic/Immunologic
- NONE
- Environmemntal Allergy
- Rheumatoid Arthritis
- Lupus
- Other:

Gastrointestinal
- NONE
- Crohn's
- Colitis
- Ulcer
- Digestive
- Other:

Integumentary/Skin
- NONE
- Eczema
- Rosacea
- Psoriasis
- Other:

Psychiatric
- NONE
- Depression
- Panic Disorder
- Schizophrenia
- Other:

Cardiovascular
- NONE
- Heart Disease
- Hypertension
- Stroke
- Vascular Disease
- Other:

Endocrine
- NONE
- Diabetes
- Thyroid
- Hormonal
- Other:

Musculoskeletal
- NONE
- Fibromyalgia
- Muscular Dystrophy
- Osteoarthritis
- Ankylosing Spondylitis
- Other:

Respiratory
- NONE
- Asthma
- Bronchitis
- Emphysema
- Other:

Neurological
- NONE
- Multiple Sclerosis
- Epilepsy
- Other:

Genitourinary
- NONE
- STD
- Prostate
- Other:

Constitutional
- NONE
- Developmental Disability
- Weight Loss
- Fever
- Fatigue
- Trauma
- Other:

Hematological/Lymphatic
- NONE
- Anemia
- Sickle Cell
- Blood Disease
- Other:

Ear/Nose Throat/Mouth
- NONE
- Upper Resp Tract Infect
- Other:

Medications

Eye Medications

DRUG ALLERGIES

	Y	N
Do you wear Glasses?		
Do you wear Contacts?		
Are you interested in Contacts?		
Are you interested in Refractive Surgery?		

Who is your Primary Care Doctor?

PCP Phone #

Patient Signature

Date