Patient Name:_____

Medical History

Past Ocular History: (Please mark all that apply)

□ **Overall Healthy**	□ Cataracts	□ Hyperopia (Far sighted)	□ Myopia (Near sighted)
□ Amblyopia (Lazy eye)	□ Diabetic Retinopathy	□ Iritis	□ Optic Neuritis
□ Aphakia	□ Dry Eyes	□ Keratoconus	□ Retinal Detachment
□ Astigmatism	□ Glaucoma	□ Macular Degeneration	

Other_____

Ocular Surgeries: (Please mark all that apply)

□ **No prior ocular surgery**	□ Foreign Body Removal	□ Punctual Plugs	□ Trabeculectomy
□ Blepharoplasty	□ Retinal Laser Surgery	□ RK (Glaucoma surgery)	□ Vitrectomy
□ Cataract Surgery	□ LASIK (Refractive Surgery)	□ Strabismus Surgery	
□ Corneal Transplant	□ PRK (Refractive Surgery)		

Other_____

Ocular Significant Illnesses: (Please mark all that apply)

□ **Overall Healthy**	□ Herpes	□ Hypothyroidism	□ Sjogren's
□ AIDS	□ HIV Positive	□ Lupus	□ Graves' disease
□ Diabetes	□ Hypertension	□ Multiple Sclerosis	□ Hyperthyroidism
□ Rheumatoid Arthritis			

Other_____

Pregnant: (please circle) YES NO OR NA **Breast Feeding:** (please circle) YES NO OR NA

Current Eye Medications: (Please list, include over-the-counter medications) _____

_____

Systemic Illnesses:

□ **No history of illnesses**	□ Congestive Heart Failure	□ Hepatitis	□ Lung Disease
□ Anemia	□ COPD	□ High Blood Pressure	□ Lupus
□ Arthritis	□ Diabetes	□ High Cholesterol	□ Migraine
□ Arrhythmia	□ Eczema	□ HIV	□ Polymyalgia
□ Asthma	□ Fibromyalgia	□ Kidney Disease	□ Psychiatric Disorder
□ Bleeding Disorder	□ Headache	□ Kidney Stones	□ Skin Cancer
□ Cancer	□ Hearing Loss	□ Liver Disease	□ Stroke
□ Thyroid Disease			

Other_____

General Surgeries / Operations: (Please list)

_____

_____

Current Other Medications/Please Include Vitamins: (Please list)

_____

_____

_____

_____

_____

Allergies: (Reaction/ Severity)

_____mild / moderate / severe

_____mild / moderate / severe

_____mild / moderate / severe

Please continue on the back side of this page →

Patient Name:_____

Infections: (Please mark all that apply)

□ Overall Healthy
□ Chicken Pox
□ Hepatitis A / B / C
□ Herpes Simplex
□ Herpes Zoster / Shingles
□ Histoplasmosis
□ HIV / AIDS
□ Meningitis
□ MRSA
□ Syphilis
□ Toxoplasmosis
□ Wound Infection

Other_____

Family History:

□ Diabetes
□ Lazy Eye
□ Heart Disease
□ Stroke
□ TB
□ Kidney Disease
□ Blindness
□ Cataracts
□ Glaucoma
□ Macular Degeneration
□ Retinal Disease
□ High Blood Pressure
□ Arthritis
□ Cancer- Type?_____

Other_____

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker □ former smoker □ never smoked

Alcohol Use: □ Yes □ No If yes how much and how often? ____

Drug Use: □ Yes □ No If yes what and how often? _____

Review of Systems: (Please mark all that apply)

Eyes
- □ Previous Surgery
- □ Contact Lens
- □ Pain
- □ Double Vision
- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Dry Eyes
- □ Flashes
- □ Floaters

Ear, Nose, and Throat
- □ Hard of Hearing
- □ Ringing in Ears
- □ Vertigo

Cardiovascular
- □ Chest Pain
- □ Dizziness
- □ Fainting Spells
- □ Shortness of Breath
- □ Irregular Heart Beat
- □ Difficulty Lying Flat

Constitutional
- □ Fatigue / Weakness
- □ Fever
- □ Weight Gain / Loss

Respiratory
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma

Gastrointestinal
- □ Heartburn
- □ Nausea / Vomiting
- □ Jaundice / Hepatitis

Genito-Urinary
- □ Pain / Difficulty
- □ Blood in Urine
- □ History of Kidney Stones
- □ History of STD's

Psychiatric
- □ Anxiety / Depression
- □ Mood Swings
- □ Difficulty Sleeping

Endocrine
- □ Increased Thirst
- □ Increased Hunger
- □ Increased Urination
- □ Increased Sweating
- □ Fingernail Changes

Blood / Lymph nodes
- □ Easy Bruising
- □ Gums Bleed Easy
- □ Prolonged Bleeding
- □ Heavy Aspirin Use

Musculoskeletal
- □ Stiffness
- □ Arthritis
- □ Joint Pain / Swelling

Skin
- □ Rash / Sores
- □ Lesions
- □ Hives / Eczema

Neurological
- □ Seizures
- □ Weakness / Paralysis
- □ Numbness
- □ Tremors

Immunologic
- □ Hives
- □ Itching
- □ Runny Nose
- □ Sinus Pressure

Do you wear glasses? □ **Yes** □ **No** If so, how old is your current pair? _____

Do you wear contact lenses? □ **Yes** □ **No** If so, how old is your current pair? _____ How often do you dispose of them? _____

Signature:_____ Date: _____