

Today's Date: \_\_\_\_\_  
MR# \_\_\_\_\_

### Personal Health History

Patient Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Please explain your present eye health and vision condition (if known):

YES  NO **Do you normally wear glasses or contacts?**  
If YES, which do you wear most of the time?  Glasses  Contacts  
If YES, how old is the prescription? \_\_\_\_\_

YES  NO **Do you have a history of any eye disease, eye surgery (including laser surgery) or eye injuries?**  
If YES, please list types and dates:

YES  NO **Are you currently taking medications of any type (including vitamins and supplements)?**  
If YES, please list:

YES  NO **Are you allergic to any medications?**  
If YES, please list medications and type of reaction:

YES  NO Not Applicable **Are you now pregnant or breast feeding?**

**Medical History: (check box YES or NO. If YES, also note date when first diagnosed.)**

- |                                    |                             |  |
|------------------------------------|-----------------------------|--|
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | <b>High Blood Pressure</b>   |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | <b>Diabetes</b>  |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | <b>Heart Disease (congestive heart failure, heart rhythm problem, heart attack, murmur), Type: _____</b> |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | <b>Lung Disease (emphysema, asthma), Type: _____</b>   |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | <b>Liver Disease, Type: _____</b>  |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | <b>Kidney Disease, Type: _____</b>   |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | <b>Gastrointestinal Disease (Crohn's, ulcerative colitis, peptic ulcer), Type: _____</b>                 |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | <b>Cancer, Type: _____</b>   |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | <b>Stroke or TIA's</b>   |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | <b>High Cholesterol</b>  |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | <b>Thyroid Disease</b>   |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | <b>Migraines</b>   |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | <b>Sleep Apnea</b>   |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | <b>Seizures</b>  |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | <b>Blood/Bleeding Disorder (anemia, blood transfusion), Type: _____</b>                                  |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | <b>Arthritis, Type: _____</b>  |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | <b>Emotional Illness (anxiety, depression)</b>   |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | <b>Cerebral Palsy</b>  |
| <input type="checkbox"/> YES _____ | <input type="checkbox"/> NO | <b>Prematurity</b>   |

Please list any other medical problems that you have been diagnosed with: \_\_\_\_\_

YES  NO **Have you ever had any surgery (not on your eyes)?**  
If YES, please list types and dates:

YES  NO **Do you smoke cigarettes or use tobacco products?**  
 NO, NOT ANY LONGER  
If YES, how much or how many cigarettes per day? \_\_\_\_\_

YES  NO **Do you drink alcohol?**  
 OCCASIONALLY

YES  NO **Are you interested in contact lenses?**

YES  NO **Are you interested in laser vision correction?**

**Is there a family history of the following?**

(Check box YES or NO. If YES, also note relationship: father, mother, etc.)

<input type="checkbox"/> YES	<input type="checkbox"/> NO	<b>Cataracts</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<b>Macular Degeneration</b>
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<b>Glaucoma</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<b>Crossed or lazy eye</b>
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<b>Retinal Disease</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<b>Migraine Headaches</b>
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<b>Diabetes</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<b>High Blood Pressure</b>
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<b>Other: _____</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<b>Blindness or tumor/cancer of the eye</b>

**Review of Systems: Do you have any of the following symptoms now?**

If NO, Please check box. If YES, please circle all words that apply.

<input type="checkbox"/> NO	<b>General:</b>	fever, chills, weight loss, night sweat, scalp tenderness
<input type="checkbox"/> NO	<b>Ears, Nose, Throat:</b>	ear pain, facial pain, chronic cough, dry mouth, sneezing
<input type="checkbox"/> NO	<b>Eye:</b>	pain, blurred vision, double vision, redness, burning, itching, discharge, light sensitivity, flashing lights, floaters
<input type="checkbox"/> NO	<b>Heart:</b>	chest pain, rapid heart beat, high blood pressure
<input type="checkbox"/> NO	<b>Respiratory:</b>	shortness of breath, difficulty breathing, discolored sputum, wheezing, congestion
<input type="checkbox"/> NO	<b>Digestive:</b>	constipation, nausea, vomiting, blood in stools, black tarry stools, diarrhea, upset stomach
<input type="checkbox"/> NO	<b>Genital, Kidney:</b>	increased urinary frequency, pain with urination, impotence
<input type="checkbox"/> NO	<b>Muscle:</b>	pain in joints, pain in muscles, stiffness, swelling, cramps
<input type="checkbox"/> NO	<b>Skin:</b>	rash, bruising, pimples, warts, growths, redness, itching, hives, swelling
<input type="checkbox"/> NO	<b>Neuro:</b>	dizziness, weakness, numbness, tingling, trouble speaking, bowel/bladder dysfunction, loss of balance, headache
<input type="checkbox"/> NO	<b>Psychiatric:</b>	Anxiety, depression, insomnia

If you answered yes to any of the above questions and are not currently receiving care for these symptoms, report them to your family physician as soon as possible.

**When did you have your last complete physical exam?**

Approximate Date: \_\_\_\_\_ Family Doctor's name: \_\_\_\_\_

**Please sign and date:** \_\_\_\_\_ (first and last name)

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_