 **MEDICAL HISTORY AND MEDICATIONS**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last eye exam?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your primary care physician?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When was last visit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any major surgeries/hospitalizations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list medication allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all the medications you are taking – including the dosage (ok to attach medication list):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you having any problems with your present glasses or contacts?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you interested in contact lenses? ⃝ yes ⃝ no Do you suffer from dry eye? ⃝ yes ⃝ no

Do you have any other hobby, recreational or occupational visual needs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current General Health Conditions:**

Fever

Weight loss/gain

High Blood Pressure

Stroke

High Cholesterol

Ears/Nose/Throat

Sinus Problems

Asthma

Respiratory Problems

Gastrointestinal

Kidney

HIV/AIDS

Arthritis

Muscle/Bone/Joint

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

Skin

Thyroid

Migraine

Seizures

Multiple Sclerosis

Anxiety/Depression

Psychiatric

Diabetes Type 1

Diabetes Type 2

Bleeding Problems

Allergies

Dry Mouth

Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pregnant or Nursing

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ocular History:**

Glaucoma

Cataracts

Macular Degeneration

Eye Injury

Retinal Disease

Blindness

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

Strabismus (eye turn)

Amblyopia (lazy eye)

Diabetic Retinopathy

Dry Eyes

Glasses/Contact Lens Correction

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**

Amblyopia

Blindness

Cataract

Macular Degeneration

Retinal Disorder

Strabismus (eye turn)

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

Arthritis

Cancer

Diabetes

Thyroid Disease

High Cholesterol

High Blood Pressure

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

⃝ yes ⃝ no

If “yes,” list the relative with the condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_