# MEDICAL HISTORY / REVIEW OF SYSTEMS

NAME: _____ CHART #: _____ DATE: _____

Name/Address/Phone Number of your Primary Doctor: _____

_____

***EYE HISTORY / SYMPTOMS:***

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Lazy / Cross Eyed | ❑ | ❑ | Glaucoma | ❑ | ❑ | Eye Pain | ❑ | ❑ |
| Blind Eye | ❑ | ❑ | Dry Eyes | ❑ | ❑ | Glare & Halos | ❑ | ❑ |
| Cataracts | ❑ | ❑ | Baggy Eyelids | ❑ | ❑ | Flashes of Light | ❑ | ❑ |
| Double Vision | ❑ | ❑ | Eye Disease / Injury | ❑ | ❑ | Glare or Trouble Seeing | ❑ | ❑ |
| Floaters | ❑ | ❑ | Itchy Eyes | ❑ | ❑ | at Night as You've Aged | | |
| Other, Please Explain _____ | | | Retinal Disease | ❑ | ❑ | | | |

_____

***DO YOU HAVE A FAMILY HISTORY OF:***

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Diabetes | ❑ | ❑ | Glaucoma | ❑ | ❑ | Retinal Disease | ❑ | ❑ |
| Macular Degeneration | ❑ | ❑ | Heart Disease | ❑ | ❑ | Arthritis | ❑ | ❑ |
| Cancer | ❑ | ❑ | High Blood Pressure | ❑ | ❑ | | | |

Do You Wear Contacts?: ❑ Yes ❑ No Type: ❑ Soft ❑ Hard

***HAVE YOU EVER HAD EYE SURGERY?*** ❑ Yes ❑ No Type of Surgery? _____

Which Eye? Right Eye Date: _____

Left Eye Date: _____

***PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY:***

Date of Last Eye Exam: _____ Doctor's Name: _____

Are You Using Eye Drops? ❑ Yes ❑ No Name of Drop: _____

How Many Times a Day? _____

***PAST SURGERY HISTORY (within past 10 years)?*** Type of Surgery? _____

_____

_____

***HAVE YOU EVER HAD OR BEEN TREATED FOR:***

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Anxiety / Depression | ❑ | ❑ | Headaches | ❑ | ❑ | Neurological Condition | ❑ | ❑ |
| Arthritis | ❑ | ❑ | Head Injury | ❑ | ❑ | Shortness of Breath | ❑ | ❑ |
| Asthma | ❑ | ❑ | Hearing Loss | ❑ | ❑ | Sinus Problems | ❑ | ❑ |
| Cancer | ❑ | ❑ | Heart Condition | ❑ | ❑ | Stroke / Seizures | ❑ | ❑ |
| Coronary Artery Disease | ❑ | ❑ | Hepatitis | ❑ | ❑ | Skin Cancer | ❑ | ❑ |
| Diabetes | ❑ | ❑ | High Blood Pressure | ❑ | ❑ | Thyroid Condition | ❑ | ❑ |
| Gastro / Intestinal Condition | ❑ | ❑ | High Cholesterol | ❑ | ❑ | | | |

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE EXPLAIN. PLEASE DESCRIBE ANY MEDICAL CONDITION OR SURGERY YOU MAY HAVE/HAD THAT IS NOT LISTED ABOVE. _____

_____

_____

_____

_____

_____

ALLERGIES: _____

***PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:*** _____

| **Name/Dose/How Often** | DATE | DATE | DATE | DATE | DATE | DATE | DATE | DATE | DATE | DATE |
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Pharmacy: _____ Location: _____ Phone #: _____

PATIENT SIGNATURE: _____ DATE: _____

***(OFFICE USE ONLY)***

Date/Initial: _____ No Change: _____ Updated/List Attached: _____
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