

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

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS ☐ Yes ☐ No

Please List All: _____

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 the 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	☐	☐			

SOCIAL HISTORY: Do you currently smoke? ☐ Yes ☐ No Have you ever smoked? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No ☐ Daily ☐ Socially ☐ Rarely

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. _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

[illegible]

PATIENT SIGNATURE: _____ DATE: _____

(OFFICE USE ONLY)

[illegible]