MEDICAL HISTORY

Name Address City State Zip Guardian (if applicable)

Date \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Phone Cell Phone Email

Birthdate / /

Last Eye Exam / /

Occupation

Do you have vision insurance? ❐ No ❐ Yes If yes, insurance carrier Do you have health insurance? ❐ No ❐ Yes If yes, insurance carrier

# Medical History

List medications you take (including oral contraceptives, aspirin, over-the-counter medications, and home remedies)

Check any of the following that you have had: ❐ age-related macular degeneration ❐ inflammatory disorder

❐ cataract ❐ strabismus ❐ kerataconus ❐ amblyopia ❐ glaucoma suspect ❐ glaucoma ❐ surgery

❐ retinal degeneration/hole/detachment ❐ patching ❐ eye injury Are you pregnant and/or nursing? ❐ No ❐ Yes

Do you wear glasses? ❐ No ❐ Yes If yes, how old is your present pair of lenses?

Do you wear contact lenses? ❐ No ❐ Yes If yes, what brand?

Type of contact lenses: ❐ Rigid ❐ Soft ❐ Extended Wear ❐ Other Are they comfortable? ❐ No ❐ Yes

# Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Disease/Condition** | **Yes** | **No** | **?** | **Relationship** |
| Thyroid Disease | ❐ | ❐ | ❐ |  |
| Diabetes | ❐ | ❐ | ❐ |  |
| Hypertension | ❐ | ❐ | ❐ |  |
| Cancer | ❐ | ❐ | ❐ |  |
| Strabismus | ❐ | ❐ | ❐ |  |
| Cataract | ❐ | ❐ | ❐ |  |
| Glaucoma Suspect | ❐ | ❐ | ❐ |  |
| Amblyopia | ❐ | ❐ | ❐ |  |
| Severe Myopia | ❐ | ❐ | ❐ |  |
| Macular Degeneration | ❐ | ❐ | ❐ |  |
| Retinal Detachment/Disease | ❐ | ❐ | ❐ |  |
| Glaucoma | ❐ | ❐ | ❐ |  |
| Severe Hyperopia | ❐ | ❐ | ❐ |  |
| Other | ❐ | ❐ | ❐ |  |

**Social History** – This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❐ Yes, I prefer to discuss my Social History information directly with the doctor.

Do you drive? ❐ No ❐ Yes If yes, do you have visual difficulty when driving? ❐ No ❐ Yes If yes, please describe:

Do you use tobacco products? ❐ No ❐ Yes If yes, type/amount/how long

Are you a ❐ Former Smoker ❐ Current Occasional Smoker ❐ Current Everyday Smoker

Do you drink alcohol? ❐ No ❐ Yes If yes, type/amount/how long

Do you use illegal drugs? ❐ No ❐ Yes If yes, type/amount/how long

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### – OVER –

Name

Date \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

**Review of Systems** Do you currently, or have you ever had, any problems in the following areas:

## Eyes

|  |  |  |
| --- | --- | --- |
| Itching | ❐ | ❐ |
| Diplopia | ❐ | ❐ |
| Burning | ❐ | ❐ |
| Mattering | ❐ | ❐ |
| Loss of Vision | ❐ | ❐ |
| Photophobia | ❐ | ❐ |
| Red | ❐ | ❐ |
| Floaters | ❐ | ❐ |
| Loss of Sharpness | ❐ | ❐ |
| Flashes | ❐ | ❐ |
| Tearing | ❐ | ❐ |

### Yes No

**Respiratory (continued)**

### Yes No

Sleep Apnea ❐ ❐

Other

## Gastrointestinal

|  |  |  |
| --- | --- | --- |
| Celiac Disease | ❐ | ❐ |
| Crohn's Disease | ❐ | ❐ |
| Ulcer | ❐ | ❐ |
| Colitis | ❐ | ❐ |
| Acid Reflux | ❐ | ❐ |

Other

## Constitutional

|  |  |  |
| --- | --- | --- |
| Developmental Disorders | ❐ | ❐ |
| Cancer | ❐ | ❐ |
| Fatigue Syndrome | ❐ | ❐ |

Other

## Ear, Nose, Mouth, Throat

Sinusitus ❐ ❐

Dry Mouth ❐ ❐

Hearing Loss ❐ ❐

Laryngitis ❐ ❐

Other

## Neurological

|  |  |  |
| --- | --- | --- |
| Epilepsy | ❐ | ❐ |
| Multiple Seizures | ❐ | ❐ |
| Tumor | ❐ | ❐ |
| Cerebral Palsy | ❐ | ❐ |
| Stroke/CVA | ❐ | ❐ |
| Migraine | ❐ | ❐ |

Other

## Psychiatric

Depression ❐ ❐

Bipolar ❐ ❐

Anxiety ❐ ❐

Attention Deficit ❐ ❐

Other

## Vascular/Cardiovascular

|  |  |  |
| --- | --- | --- |
| Vascular Disease | ❐ | ❐ |
| Stroke | ❐ | ❐ |
| Heart Disease | ❐ | ❐ |
| High Blood Pressure | ❐ | ❐ |
| Congestive Heart Failure | ❐ | ❐ |

Other

## Respiratory

|  |  |  |
| --- | --- | --- |
| Cigarette Smoker  Bronchitis | ❐  ❐ | ❐  ❐ |
| COPD | ❐ | ❐ |
| Emphysema | ❐ | ❐ |
| Asthma | ❐ | ❐ |

Other

## Genitourinary

|  |  |  |
| --- | --- | --- |
| Kidney Disease | ❐ | ❐ |
| STD - Herpetic/Chlamydia | ❐ | ❐ |
| Prostate Disease/Cancer | ❐ | ❐ |
| Pregnant/Nursing | ❐ | ❐ |

Other

## Musculoskeletal

|  |  |  |
| --- | --- | --- |
| Arthritis | ❐ | ❐ |
| Ankylosing Spondylitis | ❐ | ❐ |
| Fibromyalgia | ❐ | ❐ |
| Muscular Dystrophy | ❐ | ❐ |
| Osteoarthritis | ❐ | ❐ |
| Gout | ❐ | ❐ |

Other

## Integumentary

|  |  |  |
| --- | --- | --- |
| Herpes Simplex/Cold Sores | ❐ | ❐ |
| Herpes Zoster/Shingles | ❐ | ❐ |
| Rosacea | ❐ | ❐ |
| Psoriasis | ❐ | ❐ |
| Eczema | ❐ | ❐ |

Other

## Endocrine

|  |  |  |
| --- | --- | --- |
| Diabetes Type II | ❐ | ❐ |
| Thyroid Dysfunction | ❐ | ❐ |
| Hormonal Dysfunction | ❐ | ❐ |
| Diabetes Type I | ❐ | ❐ |

Other

## Hematologic/Lymphatic

Large Volume Blood Loss ❐ ❐

Anemia ❐ ❐

Ulcer ❐ ❐

High Cholesterol ❐ ❐

Other

## Allergic/Immunologic

Environmental Allergies ❐ ❐

Lupus ❐ ❐

Rheumatoid Arthritis ❐ ❐

Drug Allergies ❐ ❐

If yes, what drug? Sjogrens Syndrome ❐ ❐

Other

**Wellness Fundus Photo:** Wellness photo of your retina will allow the Doctor to have an image to compare the health of your retina and optic nerve over the course of the time. Wellness photo is not covered by insurance and will be a fee of $39.

 Yes  No