MEDICAL/EYE HISTORY

Patient Name____ Date ________________

Please answer the following questions about your medical and eye history.

Have you ever had any eye condition, surgery or injury?

❒ No ❒ Yes, please explain____

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What is your chief complaint about your eyes? _______________________________

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When did it start? ____

Have you had this before? ____

Are you currently experiencing any of the following symptoms?

❒ Eye pain	❒ Blurred vision	❒ Eyelid crusting	❒ Flashes of light
❒ Itching	❒ Dryness	❒ Tearing	❒ Floaters
❒ Halos	❒ Discharge	❒ Sandy feeling	❒ Light sensitivity

Please list all **eye** medications you are currently using— list names and how often

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Please list all **medical conditions** you are being treated for

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Have you ever had any surgeries/injuries/or hospitalizations?

❒ No ❒ Yes. Please List ____

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Please list all medications (including vitamins) that you are currently using

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Please list any drug or food allergies that you have ______________________________

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Do you smoke?	❒ No	❒ Yes. How much? ______________	
Have you ever smoked?	❒ No	❒ Yes	
Do you drink alcohol?	❒ No	❒ Yes. How often? ______________	
Do you use street drugs?	❒ No	❒ Yes	

Do you currently have any of the following problems?	**No**	**Yes**	**If Yes, please explain**
Chronic Fever, unexpected weight loss/gain, fatigue	❒	❒	______________
Ear/Nose/Throat - hearing loss, sinus, sore throat, etc.	❒	❒	______________
Heart - chest pain, HTN, cholesterol, irregular heartbeat, etc.	❒	❒	______________
Respiratory - asthma, COPD, shortness of breath, etc.	❒	❒	______________
Gastrointestinal - GERD, heartburn, diarrhea, vomiting, etc.	❒	❒	______________
Urinary - pain, blood in urine, ulcer, discomfort, etc.	❒	❒	______________
Skin - rashes, rosacea, change in hair/nails, dryness, etc.	❒	❒	______________
Musculoskeletal - gout, arthritis, joint pain/swelling, etc.	❒	❒	______________
Neurological - numbness,weakness,paralysis, etc.	❒	❒	______________
Hematologic – blood diseases, etc.	❒	❒	______________
Psychiatric – depression, anxiety, etc.	❒	❒	______________
Immunologic – disorders, food/seasonal allergies, etc.	❒	❒	______________
Endocrine – diabetes, thyroid, hypoglycemia, etc.	❒	❒	______________
AIDS/HIV, MRSA, Hepatitis	❒	❒	______________

Has anyone in your family been diagnosed with diabetes, cardiovascular disease, high blood pressure, carotid artery disease, glaucoma, cataracts, retinal disease or macular degeneration?

❒ No ❒ Yes, please list what relationship and disease

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Signature____ Date ____________________

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