Medical and Ocular History Form

Patient's name _____ Date of birth _____ Date_____

Date of last medical exam _____ Medical doctor _____

Date of last eye exam _____ Previous eye doctor _____

PERSONAL MEDICAL HISTORY

Do you currently have or have ever had the following conditions, check those that apply.

General Health
☐ Currently Pregnant/Nursing
☐ Developmental Disability
☐ Cancer – Type _____
☐ Tobacco Use
☐ Alcohol Use
☐ Drug Use

Allergic/Immunologic
☐ Drug Allergy _____
_____
_____
_____
_____
☐ Environmental Allergy _____
_____
_____
_____
☐ Rheumatoid Arthritis

Cardiovascular
☐ Hypertension/High Blood Pressure
☐ Stroke
☐ Heart Disease

Endocrine
☐ Diabetes
Date diagnosed _____
A1c _____
☐ Hyperthyroid
☐ Hypothyroid

Neurological
☐ Multiple Sclerosis
☐ Epilepsy
☐ Head Trama
☐ Headaches/Migraines

Hematological/Lymphatic
☐ Anemia
☐ Leukemia

Respiratory
☐ Asthma
☐ Emphysema
☐ Frequent Sinus Infections

Dermatologic
☐ Rosacea
☐ Eczema
☐ Psoriasis

Musculoskeletal
☐ Osteoarthritis
☐ Muscular Dystrophy
☐ Ankylosing Spondylitis
☐ Fibromyalgia

Psychiatric
☐ Depression
☐ Anxiety
☐ Bipolar

Gastrointestinal
☐ _____
_____

Genitourinary
☐ _____
_____

Ears, Nose, Throat
☐ _____
_____

Infectious Disease
☐ HIV/AIDS
☐ Hepatitis
☐ Tuberculosis
☐ STDs _____

Other _____
_____
_____

Medications
Please list all you presently take
_____
_____
_____
_____
_____
_____
_____
_____

Eyes
☐ Eye Allergies
☐ Eye Injury
☐ Frequent Eye Infections
☐ Lazy/Crossed Eyes
☐ Dry Eyes
☐ Double Vision
☐ Prism in glasses
☐ Cataracts
☐ Glaucoma
☐ Macular Degeneration
☐ Retinal Detachment
☐ Blindness
☐ Other _____
_____
_____
_____

Eye Surgeries
_____
_____
_____

Major Medical Surgeries
_____
_____
_____

Family History

Does any family member (parents, siblings, grandparents & children) currently have or had any of the following? Please write relationship
☐ Blindess _____
☐ Cataracts _____
☐ Glaucoma _____
☐ Macular Degeneration _____
☐ Retinal Detachment _____
☐ Lazy/Crossed Eye _____
☐ Retinal Disease _____
☐ Cancer _____
☐ Diabetes _____
☐ Heart Disease _____
☐ Hypertension _____
☐ Thyroid Disease _____