Patient Name:_____ DOB:_____

Primary Care Physician:_____Last Medical Physical:_____

GENERAL HEALTH HISTORY

Your vision as well as ocular health can be affected by different medical conditions and systemic medications. This information helps the Doctor provide a more thorough eye health exam.

Do you **currently** have any of the following:

Y	N		Y	N	
__	__	Fever/Weight Loss	__	__	Stomach/Intestinal Problems
__	__	Ears/Mouth/Nose/Throat	__	__	Kidney/Urinary/Genital Disease
__	__	Sinus Problems	__	__	Joint/Muscle Pain
__	__	High Blood Pressure	__	__	Skin Problems
__	__	High Cholesterol	__	__	Headaches
__	__	Irregular Heart Beat	__	__	Stroke/Neurological Disease
__	__	Angina	__	__	Depression/Psychiatric Problems
__	__	Asthma/Emphysema	__	__	HIV/AIDS
__	__	Other Lung Disease	__	__	Seasonal Allergies
__	__	Diabetes	__	__	Reactions to Anesthetics
__	__	Thyroid	__	__	Smoking __ Never Smoked

Other:_____

_____

Are you currently pregnant? Y/N Trimester?_____

MEDICATIONS: Please list all medicines, including aspirin, that you take.(Do not list eye meds.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES: Please list any allergies to **medications** that you have and the reaction it causes:

_____

_____

ILLNESSES/INJURIES: Please list all major illness or injuries that you have had or currently have:

_____

_____

SURGERIES: Please list all **past** surgeries (except eye surgeries) that you've had:

_____

_____

FAMILY HISTORY: Please list all medical conditions that affect your parents, siblings and children:

_____

_____

EYE HISTORY

Date of Last Eye Exam:_____ Previous Eye Doctor:_____

EYE DISEASE: Do you have now, or have you ever had any of the following eye diseases?

Y	N		Y	N	
__	__	Cataract	__	__	Crossed Eyes
__	__	Glaucoma	__	__	Lazy Eye
__	__	Detached Retina	__	__	Eye Injury
__	__	Diabetic Retinopathy	__	__	Macular Degeneration

Other:_____
_____

EYE SURGERY AND LASER: Please list all eye or eyelid surgeries and lasers that you have had:
_____
_____

GLASSES AND CONTACT LENSES: Do you currently wear glasses or contact lenses?

__ Glasses for Distance __ Glasses for Reading __ Rigid Contact Lenses __ Soft Contact Lenses

FAMILY EYE HISTORY: Have your parents, siblings or children had any of the following?

Y	N		Y	N	
__	__	Cataract	__	__	Macular Degeneration
__	__	Glaucoma	__	__	Blindness
__	__	Detached Retina	__	__	_____ (Other)

EYE MEDICATIONS: Please list all medicines that you are currently using for your eyes:

Medication	**Eye**	**Frequency**	**Medication**	**Eye**	**Frequency**
_____	___	_____	_____	___	_____
_____	___	_____	_____	___	_____

If patient is a child, may we dilate their eyes today?_____

Patient Name Printed:_____

Patient Signature:_____ Date:_____
(Parent or Guardian if patient is a child)