

Medical History

Name: _____ Date: _____ Last Eye Exam: _____

Who is your Primary Care Physician: _____ Clinic: _____

Please check any condition(s) which apply to your health:

- | | | |
|---|--|---|
| <input type="checkbox"/> No current Health Problems | | |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Herpes Infection | <input type="checkbox"/> Lung Condition |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> AIDS, HIV Positive | <input type="checkbox"/> Sjogren's |
| <input type="checkbox"/> Cancer Type: _____ | <input type="checkbox"/> Stroke | <input type="checkbox"/> Crohn's |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Lupus Erythematosus | <input type="checkbox"/> Elevated Blood Cholesterol |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Severe Blood Loss | <input type="checkbox"/> Other of Surgeries. Explain:

_____ |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pregnant | |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Keloids | |
| <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> Asthma | |

Please check any conditions which apply to your eye health:

- | | | |
|---|--|--|
| <input type="checkbox"/> Amblyopia (lazy eye) | <input type="checkbox"/> Previous Eye Surgery | <input type="checkbox"/> Cornea Transplant |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Persistent Red or Dry Eyes | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Previous Refractive Surgery
(ALK, RK, AK, Laser) | <input type="checkbox"/> Loss of Vision (blind spot or area) |
| <input type="checkbox"/> Recurrent Eye Infections | <input type="checkbox"/> Loss of Eye | <input type="checkbox"/> Previous Contact Lens Wear |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Thyroid Eye Condition | <input type="checkbox"/> Retinal (Macular) Degeneration |
| <input type="checkbox"/> Eye Allergies | <input type="checkbox"/> Diabetes Eye Condition | <input type="checkbox"/> Eye Tumor |
| <input type="checkbox"/> Eye Turn (Strabismus) | <input type="checkbox"/> Iritis | Other _____ |
| <input type="checkbox"/> Previous Eye Injury | | |

To the best of your knowledge, do any of these conditions exist or have existed in any of your blood relatives? Check any which apply.

- | | |
|---|---|
| <input type="checkbox"/> Adopted Family history not known | <input type="checkbox"/> Eye Turn (Strabismus) |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Retinal (Macular) Degeneration |
| <input type="checkbox"/> Eye Cancer | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Lazy Eye (Amblyopia) | |

Please list any current medicines, eye drops, injections, or health devices you currently use. This includes non-prescription items as well as prescription items (for example, Tylenol and oral contraceptives).

1. _____ For: _____
2. _____ For: _____
3. _____ For: _____
4. _____ For: _____
5. _____ For: _____
6. _____ For: _____
7. _____ For: _____

Are you allergic to any medications? _____

WHAT IS YOUR PRIMARY REASON FOR YOUR EXAMINATION TODAY?

How many hours per day do you spend on a computer? _____

Are you interested in contact lens vision correction?

Yes No

Are you interested in refractive surgery vision correction?

Yes No