

Medical History

Name: _____ Date: _____ Last Eye Exam: _____

Who is your Primary Care Physician: _____ Clinic: _____

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

- __ No current Health Problems
__ Allergies
__ Anemia
__ Cancer Type: _____
__ Diabetes
__ Heart Condition
__ High Blood Pressure
__ Kidney Disease
__ Headaches
__ Thyroid Condition
__ Herpes Infection
__ AIDS, HIV Positive
__ Stroke
__ Arthritis
__ Lupus Erythematosus
__ Severe Blood Loss
__ Pregnant
__ Keloids
__ Asthma
__ Lung Condition
__ Sjogren's
__ Crohn's
__ Acne
__ Elevated Blood Cholesterol
__ Other of Surgeries. Explain:

Please check any conditions which apply to your eye health:

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

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.

- __ Adopted Family history not known
__ Glaucoma
__ Diabetes
__ Cataracts
__ Eye Cancer
__ Lazy Eye (Amblyopia)
__ Eye Turn (Strabismus)
__ Retinal Detachment
__ Migraine Headaches
__ Retinal (Macular) Degeneration
__ Other _____

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