PATIENT MED-HISTORY

Patient Status:_______________________________________

Name: ____

Address:____

City:_____________________________________ **State:** _________________ **Zip Code:** ____________________

Primary Phone: ______________________________ **Secondary Phone:**__________________________________

Email: ____

Primary Care Doctor: __________________________ **Primary Care Phone Number:**______________________

Primary Care Doctor Email:____

Do you currently wear:

	Yes	No
Glasses		
Contact Lenses		
Low Vision Aids		

Do you currently have or have you ever had any of the following:

	Yes	No
Eye Surgeries		
Eye Injuries		
Eye Infections		
Amblyopia		
Cataracts		
Dry Eyes		
Light Sensitivity		
Pain		
Glaucoma		
Lazy Eye		
Macular Degeneration		
Eye Turn In / Out		
Reading Problems		
Tracking Problems		
Other		

Do you Have:

	Yes	No
Diabetes		
High Blood Pressure		
Headaches		

Medication - List any Medications:

Are you currently taking	Yes	No
Prescription or non-prescription drugs?		

List any medication and dosage:

Allergies - List any known Allergies:

Do you currently have any Allergies	Yes	No
Known or perceived?		

List any allergies:

Do you have problems with any of these systems? - Please check all that apply

	Yes	No
Allergic / Immunologic		
Arthritis		
Blood / Lymph		
Cardiovascular Heart Disease		
Ear / Nose / Throat		
Endocrine Glands		
Gastrointestinal		
Integument Skin		
Kidney Problems		
Musculature		
Nervous		
Psychiatric		
Respiratory		
Skeletal Bones		
Thyroid Problems		
Other (explain bottom of page)		

Do you use - Please select all that apply

	Yes	No
Cigarettes?		
Alcohol?		
Other substances?		

Family Eye History - Anyone in patient's family (blood relative) had any of the following?

	Yes	No
Cataracts		
Cornea Disease		
Diabetes		
Glaucoma		
Lazy Eye		
Macular Degeneration		
Retina Disease		
High Blood Pressure		
Other Eye Disorders		

Your Surgical History- List any type of surgery and dates of surgery

Other Information- Please elaborate on any information