

Medical History

Patient Name: _____

Please tell us reasons for your visit today (Please select all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Need updated contacts | <input type="checkbox"/> Recommended by School | <input type="checkbox"/> Diabetic Annual Exam |
| <input type="checkbox"/> Need updated glasses | <input type="checkbox"/> Recommended by Doctor | <input type="checkbox"/> My parents made me come |
| <input type="checkbox"/> Yearly eye exam | <input type="checkbox"/> Other reason: _____ | |

Do you have any of the following symptoms?

NONE

- | | | |
|--|---|--|
| Blurred distance vision <input type="checkbox"/> Yes | Headache <input type="checkbox"/> Yes | Dryness <input type="checkbox"/> Yes |
| Blurred near vision <input type="checkbox"/> Yes | Poor night vision <input type="checkbox"/> Yes | Redness <input type="checkbox"/> Yes |
| Eyestrain <input type="checkbox"/> Yes | Night glare <input type="checkbox"/> Yes | Burning <input type="checkbox"/> Yes |
| Eye pain <input type="checkbox"/> Yes | Double vision <input type="checkbox"/> Yes | Itching <input type="checkbox"/> Yes |
| Light sensitivity <input type="checkbox"/> Yes | Fluctuating vision <input type="checkbox"/> Yes | Tearing <input type="checkbox"/> Yes |
| Floaters or spots <input type="checkbox"/> Yes | Loss of vision <input type="checkbox"/> Yes | Discharge <input type="checkbox"/> Yes |

Other: _____

Have you had any EYE conditions?

NONE

- Cataracts Yes
- Macular Degeneration Yes
- Glaucoma Yes
- Diabetic Retinopathy Yes
- Dry Eye Yes
- Strabismus (eye turn) Yes
- Amblyopia (lazy eye) Yes
- Iritis or Uveitis Yes
- Retinal Holes or Tears Yes
- Retinal Detachment Yes
- Keratoconus Yes
- Eye Injury or Trauma Yes
- Surgery: Yes

Other: _____

Have any HEALTH conditions? (Circle those that apply)

NONE

- Constitution (Developmental Disability, Fatigue Syndrome, Cancer Type: _____) Yes
- Ear, Nose, Throat (Hearing loss, Sinusitis, Dry mouth...) Yes
- Neurological (Epilepsy, CP, MS, Stroke, Migraines...) Yes
- Psychological (Depression, Bipolar, Anxiety...) Yes
- Cardiovascular (Blood pressure, Stroke, CHF...) Yes
- Respiratory (Asthma, COPD, Sleep Apnea, Emphysema...) Yes
- Gastrointestinal (Crohn's, Colitis, Ulcers, Celiac...) Yes
- Genitourinary (Kidney, Prostate, STDs, Herpes...) Yes
- Musculoskeletal (Gout, Arthritis, Fibromyalgia...) Yes
- Integ/Skin (Eczema, Rosacea, Psoriasis, Herpes...) Yes
- Endocrine (Diabetes Type I or II, Thyroid, Hormones...) Yes
- Blood Disease (Cholesterol, Anemia, Sickle...) Yes
- Autoimmune (Rheumatoid Arthritis, Lupus, Sjogrens...) Yes
- Other: _____

*** PLEASE TURN OVER ***

