



**PATIENT HISTORY**

Name: \_\_\_\_\_

Medical History

Medications you take (including oral contraceptives and over the counter):

Are you allergic to any medications? Yes    No

Are you currently being treated for any medical condition? Yes    No  
 If yes, explain:

Are you pregnant or nursing? Yes    No

Do you smoke? (If so how much) Yes    No

	Yes	No
Chronic fever, unexpected weight loss, fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Ear, nose, throat problems, sinusitis, hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems, chest pain, irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory problems, wheezing, cough, shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal problems, diarrhea, vomiting, heartburn, pain	<input type="checkbox"/>	<input type="checkbox"/>
Urinary problems, pain, discharge, blood in urine, urgency	<input type="checkbox"/>	<input type="checkbox"/>
Skin problems, acne, seborrhea, eczema, psoriasis, rashes	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal problems, aching, joint pain, joint swelling	<input type="checkbox"/>	<input type="checkbox"/>
Neurologic symptoms, numbness, weakness, headaches	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric problems, depression, anxiety, agitation	<input type="checkbox"/>	<input type="checkbox"/>

Eye Conditions	Yes	No	General Health Conditions	Yes	No
Glaucoma			Diabetes		
Cataracts			High Blood Pressure		
Retinal Detachment/Retinal Problem			Heart Disease		
Lazy Eye/Amblyopia			Breathing Problems		
Eye Surgery			Auto-Immune Disease		
Dry Eye			Arthritis		
Eye Injury/Infection			Seasonal Allergies		
Other (list):			Other (list):		

Eye History

When was your last eye exam? Doctors Name/ City:

How old are your present glasses? Do you wear contacts?    Yes    No    How old are your contacts?

When do you use glasses/contacts?    Constantly                      Reading Only                      Distance Only                      Rarely

Notes and items you think we should know about, not listed or described above: