GENERAL MEDICAL HISTORY

Primary Physician					Physician's Phone Number	When was your last physical exam?
Check the box for any conditions that apply:						
	You	Mom	Dad	Sib	Describe	
Diabetes	O	O	O	O	O Type 1 O Type 2 Year Diagnosed:	Last A_1c level:
Hypertension	O	O	O	O		
Thyroid Disease	O	O	O	O		
Cardiovascular Disease	O	O	O	O		
Cancer	O	O	O	O		
Check if applicable: O Pregnant O Nursing					Do you live alone? O Yes O No O Assisted Living O Nursing Home	
List ALL major injuries or surgeries, including approximate year:						
List any other medical conditions you have, including non-drug allergies:						

Review of Systems- list (or circle) any complaints you are currently having anywhere, from head to toe:

General (e.g., fever, fatigue, loss of appetite, unexplained weight loss/gain):
Ear, Nose, Throat (e.g., sinus/nasal congestion, nose bleeds, dry mouth/throat, sleep apnea, hearing problems):
Cardiovascular (e.g., chest pain, racing heartbeat, swollen feet/ankles, TIAs):
Respiratory (e.g., chronic cough, shortness of breath, wheezing):
Genital, Kidney, Bladder (e.g., bladder/urinary problems, pain, discharge, menstrual changes, impotence):
Gastrointestinal (e.g., constipation, diarrhea, gastric reflux (GERD), jaundice, nausea, vomiting):
Endocrine (e.g., heat or cold intolerance, thinning hair, excess thirst, excess urination):
Muscles, Bones, Joints (e.g., pain, stiffness, swelling, weakness, limited movements):
Skin (e.g., dry, itchy, flaky, rash, growths, bumps, redness, discoloration):
Neurological (e.g., headaches, numbness/tingling, tremors, poor balance, dementia, speech problems):
Psychiatric (e.g., depression, anxiety, sleep problems, paranoia, obsessive/compulsive):
Blood/Lymph (e.g., anemia, bleeding gums, delayed clotting, unexplained bruising):
Allergy/Immune (e.g., swollen lymph nodes, itching, sneezing, runny nose/eyes):

OCULAR HISTORY

Who was your previous eye doctor?	When was your last eye exam?

What is the primary reason for your appointment today?

List any additional vision complaints you are having such as:

- blurred vision, headaches, eyestrain, double vision or losing your place when reading;
- itching, burning, redness, light sensitivity, watering, crusting or mucous discharge;
- seeing dark spots, squiggles or webs, bright flashes or colored rainbows around lights at night.

Check all that apply to	You	Mom	Dad	Sib	Describe (when diagnosed, explanation of problem)
Glaucoma	O	O	O	O	
Macular Degeneration	O	O	O	O	
Retinal Problems	O	O	O	O	
Cataracts	O	O	O	O	
Lazy eye/Eye turn	O	O	O	O	

List major EYE injuries, infections, or surgeries, including approximate year:

List any other eye problems you have had in the past:

List any EYE drops you use (RX or OTC)

How many hours/day do you typically spend:

Reading books, magazines, etc.? Using computers/digital devices?

If you're having issues with computer work, how far is the monitor from your eyes?

Are you interested in contacts? O Y O N	Do you have back-up glasses? O Y O N	Do you have sunglasses? O Y O N

What are your hobbies?

Smoking History	Alcohol use:
O Never O Former Smoker O less than 10/day O 10+/day	O None O Occasional O Social O 1 drink/day O 2+ drinks/day

List any drug allergies you have:

List any vitamins/supplements you take:

List all Rx and over-the-counter medications you take, including dosage:

Contact Lens Wearers Only

If new to our clinic – What brand are you wearing?

Any problems with comfort?	Vision complaints?	What disinfecting solution do you use?
What is your average wear time?	How often do you replace your contacts?	How old is your current pair of lenses?