MEDICAL AND EYE HISTORY

Name: ______________________________ Date of Birth: ____________ Age: ___ Sex: ___

Height________________________________ Weight__________________

Chief Complaint:____

Please fill out the information below completely regarding your medical information.

	YES	NO
Diabetes? HgA1c = ____	☐	☐
High blood pressure?	☐	☐
Chest pain?	☐	☐
History of heart disease?	☐	☐
Swollen legs/ankles?	☐	☐
Shortness of breath?	☐	☐
Asthma or emphysema?	☐	☐
Abdominal pain?	☐	☐
Nausea/vomiting?	☐	☐
Diarrhea or constipation?	☐	☐
Currently pregnant?	☐	☐
Blood in urine?	☐	☐
Oral or genital sores?	☐	☐
Fever?	☐	☐
Recent weight change?	☐	☐
Rashes or changed skin color?	☐	☐
History of thyroid disease?	☐	☐
Headaches?	☐	☐
Seizures?	☐	☐
Hearing loss?	☐	☐
History of stroke or TIA?	☐	☐
Numbness/weakness?	☐	☐
Joint pain?	☐	☐
Back pain?	☐	☐
Jaw pain?	☐	☐
Scalp tenderness?	☐	☐
Anemia?	☐	☐
Bleeding problems?	☐	☐
Swollen glands in neck?	☐	☐
History of HIV?	☐	☐
History of cancer?	☐	☐
Which? _____________		
Depression or anxiety?	☐	☐
Other disease?	☐	☐

	YES	NO
Eye or head injury?	☐	☐
Glaucoma?	☐	☐
History of macular degeneration?	☐	☐
History of retinal detachment?	☐	☐
Myopia?	☐	☐
Eye surgery?	☐	☐
Lazy eye?	☐	☐
Eye or head injury?	☐	☐
Dry eyes?	☐	☐
Ocular Allergies?	☐	☐
Family member with:		
Macular degeneration?	☐	☐
Retinal detachment?	☐	☐
Other eye disease?	☐	☐
History of drug abuse?	☐	☐
≥ 6 drinks/week of alcohol?	☐	☐
Do you smoke?	☐	☐

Medication Allergies: ________________

Medications (including eye drops):
~Please list on the back of form if necessary~

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____

____

Medical Problems/Surgeries/Hospitalizations (please include year):

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