

Name: _____ Birthdate: _____ Date: _____

Medical History Information

Please mark (✓) if you have had any of the following problems with your eyes:

- | | | |
|---|---|--|
| <input type="checkbox"/> dryness | <input type="checkbox"/> night blindness | <input type="checkbox"/> eye disease |
| <input type="checkbox"/> feeling gritty | <input type="checkbox"/> flashes of light | <input type="checkbox"/> seeing spots |
| <input type="checkbox"/> redness | <input type="checkbox"/> sensitive to light | <input type="checkbox"/> tiring easily |
| <input type="checkbox"/> itching | <input type="checkbox"/> aching | <input type="checkbox"/> watering |
| <input type="checkbox"/> headaches | <input type="checkbox"/> floaters | |

Have you had any unusual work or leisure time (hobbies) demands on your eyes?

No Yes Please describe: _____

Please mark (✓) if you or "blood relative" has had any of the following:

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> allergies | <input type="checkbox"/> cataracts | <input type="checkbox"/> eye disease |
| <input type="checkbox"/> blindness | <input type="checkbox"/> heart disease | <input type="checkbox"/> glaucoma |
| <input type="checkbox"/> cancer | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> stroke |
| <input type="checkbox"/> thyroid disorder | <input type="checkbox"/> diabetes | |

Please mark (✓) if you have had any of the following problems with these systems:

- | | | |
|--|---|---|
| <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Nervous | <input type="checkbox"/> Endocrine |
| <input type="checkbox"/> Ears/Nose/Throat | <input type="checkbox"/> Urinary | <input type="checkbox"/> Blood/Lymph |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Muscle/Bones | <input type="checkbox"/> Allergic/Immunologic |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Integumentary (Skin) | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Eyes | <input type="checkbox"/> Mental |

Please explain: _____

Diabetes No Yes Type _____ Date of diagnosis: _____

Allergies to medication(s): No Yes Which? _____

Reactions? _____

Other health problems: _____

Please list any medications you are now taking:

Date reviewed and Initial: (office use only)