Reset Form

eyephysicians
everything in sight for your family

MEDICAL HISTORY

PATIENT NAME: _____ DATE: _____

DATE OF BIRTH: _____

YOUR GENERAL MEDICAL INFORMATION - please check all that apply to YOU

GENERAL:
☐ weight loss or gain ☐ chronic fatique ☐ fever

EAR/NOSE/THROAT:
☐ hearing loss ☐ ear infection ☐ sore throat ☐ sinus problems

CARDIOVASCULAR:
☐ heart disease ☐ high blood pressure ☐ irregular heartbeat ☐ chest pain

RESPIRATORY:
☐ asthma ☐ emphysema ☐ bronchitis ☐ shortness of breath

GASTROINTESTINAL:
☐ ulcers ☐ colitis ☐ diarrhea ☐ constipation ☐ blood in stool heartburn

KIDNEY/BLADDER:
☐ dialysis ☐ bladder infection

MUSCULOSKELETAL:
☐ fibromyalgia ☐ arthritis ☐ ankylosing spondylitis ☐ joint pain/swelling

SKIN:
☐ acne ☐ eczema ☐ rosacea ☐ psoriasis ☐ dry skin ☐ skin cancer

NEUROLOGICAL:
☐ stroke ☐ seizures ☐ headaches ☐ migraines ☐ weakness in arms or legs

MENTAL HEALTH:
☐ anxiety ☐ depression ☐ insomnia

ENDOCRINE:
☐ diabetes ☐ thyroid disorder ☐ hormone imbalance

BLOOD:
☐ anemia ☐ high cholesterol ☐ leukemia

IMMUNOLOGY:
☐ medication allergies ☐ environmental allergies ☐ food allergies

OTHER CONDITIONS NOT LISTED ABOVE: _____

BMI: Your Height _____ Your Weight _____

ARE YOU CURRENTLY PREGNANT OR NURSING: ☐ Yes ☐ No

YOUR PERSONAL OCULAR HISTORY - please check all that apply to YOU

HAVE YOU EVER BEEN DIAGNOSED WITH THE FOLLOWING:

☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Dry Eye
☐ Retinal Detachment ☐ Crossed or "Lazy" eyes

PLEASE LIST ANY OTHER EYE INJURY, SURGERY, OR EYE DISEASE THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST:

_____

DO YOU CURRENTLY EXPERIENCE?

☐ mattery eyes ☐ sensitivity to light ☐ sudden loss of vision ☐ reading difficulty
☐ blurry distance vision ☐ blurry near vision ☐ objects floating in your vision ☐ watery eyes
☐ eyestrain ☐ headaches ☐ double vision ☐ redness of eyes ☐ flashes of light in your vision

DO YOU CURRENTLY WEAR CONTACT LENSES? ☐ Yes ☐ No

IF NO, ARE YOU INTERESTED IN TRYING CONTACT LENSES? ☐ Yes ☐ No

ARE YOU INTERESTED IN SURGICAL METHODS, SUCH AS LASIK, TO CORRECT YOUR VISION? ☐ Yes ☐ No

YOUR PERSONAL SOCIAL HISTORY - please check all that apply to YOU

ALCOHOL USE:

☐ Never Occasionally ☐ One drink per day ☐ More than one drink daily

TOBACCO USE:

☐ Never ☐ Previously but not currently ☐ Less than 1 pack per day ☐ More than 1 pack per day

FAMILY MEDICAL HISTORY - please check all that apply

DO ANY OF YOUR BLOOD RELATIVES HAVE THE FOLLOWING?

☐ Heart Disease ☐ High Blood Pressure ☐ Stroke ☐ Cancer ☐ Diabetes ☐ Lung Disease

FAMILY EYE HISTORY - please check all that apply

DO ANY OF YOUR RELATIVES HAVE THE FOLLOWING?

☐ Cataracts ☐ Macular Degeneration ☐ Retinal Detachment ☐ Lazy Eye
☐ Glaucoma ☐ Dry Eyes

PLEASE USE THE REST OF THIS PAPER TO LIST ALL MEDICATIONS (INCLUDING VITAMINS, EYE DROPS AND NON-PRESCRIPTION SUPPLEMENTS) THAT YOU ARE CURRENTLY USING.

_____

_____

_____

_____

_____

PATIENT SIGNATURE: _____