MEDICAL HISTORY

NAME____ DOB_______________________________________

EMERGENCY CONTACT______________________________PHONE #____

BRIEFLY STATE ANY VISUAL PROBLEMS____

ARE YOU ALLERGIC TO ANY MEDICATIONS? IF YES, PLEASE LIST: ____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING____

____

____

LIST ALL MAJOR SURGERIES____

ARE YOU PREGNANT OR NURSING? Y N
DO YOU WEAR GLASSES Y N
DO YOU WEAR CONTACTS Y N

FAMILY HISTORY

PLEASE CIRCLE ANY FAMILY MEMBERS (PARENTS, GRANDPARENTS, SIBLINGS, LIVING OR DECEASED) WITH ANY OF THE FOLLOWING MEDICAL CONDITIONS. USE A QUESTION MARK IF UNSURE.

	RELATIONSHIP TO YOU		RELATIONSHIP TO YOU
CATARACTS		DIABETES	
CROSSED EYES		HEART DISEASE	
GLAUCOMA		HIGH BLOOD PRESSURE	
MACULAR DEGENERATION		KIDNEY DISEASE	
RETINAL DISEASE		LUPUS	
ARTHRITIS		THYROID DISEASE	
CANCER		OTHER	

REVIEW OF SYSTEMS

DO YOU CURRENTLY OR HAVE YOU EVER HAD PROBLEMS IN THE FOLLOWING AREAS?
(USE A QUESTION MARK IF YOU ARE NOT SURE)

CONSTITUTIONAL Y N
FEVER/WEIGHT GAIN OR LOSS

INTEGUMENTARY **Y** **N**
SKIN

NEUROLOGICAL
HEADACHES Y N

EYES
LOSS OF VISION Y N
BLURRED VISION Y N

EARS/NOSE/THROAT
SINUS CONGESTION Y N
DRY THROAT/MOUTH Y N
CHRONIC COUGH Y N
POST-NASAL DRIP Y N
ALLERGIES Y N

RESPIRATORY
ASTHMA Y N
CHRONIC BRONCHITIS Y N
EMPHYSEMA Y N

EYES (CONT)

DISTORTED VISION		
HALOS	Y	N
LOSS OF SIDE VISION	Y	N
DOUBLE VISION	Y	N
DRYNESS	Y	N
MUCOUS DISCHARGE	Y	N
REDNESS	Y	N
SANDY/GRITTY	Y	N
ITCHING	Y	N
BURNING	Y	N
FOREIGN BODY	Y	N
SENSATION	Y	N
EXCESS TEARING	Y	N
GLARE/LIGHT		
SENSITIVITY	Y	N
EYE PAIN	Y	N
CHRONIC INFECTION	Y	N
OF LID OR EYE	Y	N
STIES/CHALAZION	Y	N
FLASHES OR FLOATERS	Y	N
TIRED EYES	Y	N
CROSSED EYES	Y	N
LAZY EYE	Y	N
DROOPY LID	Y	N
PROMINENT EYE	Y	N
GLAUCOMA/		
EYE PRESSURE	Y	N
RETINAL DISEASE	Y	N
CATARACTS	Y	N
EYE INJURY	Y	N

VASCULAR/CARDIOVASCULAR

DIABETES	Y	N
HEART PAIN	Y	N
HIGH BLOOD		
PRESSURE	Y	N
VASCULAR DISEASE	Y	N

GASTROINTESTINAL

DIARRHEA	Y	N
CONSTIPATION	Y	N

GENITOURINARY

GENITALS/KIDNEY		
BLADDER	Y	N

BONES/JOINTS/MUSCLES

RHEUMATOID		
ARTHRITIS	Y	N
MUSCLE PAIN	Y	N
JOINT PAIN	Y	N

LYMPHATIC/HEMATOLOGIC

ANEMIA	Y	N
BLEEDING PROBLEM	Y	N

ENDOCRINE

THYROID/OTHER		
GLANDS	Y	N

ALLERIC/IMMUNOLOGIC Y N

PSYCHIATRIC Y N

SOCIAL HISTORY

DO YOU DRIVE Y N IF YES, DO YOU HAVE DIFFICULTY WHEN DRIVING? Y N
PLEASE EXPLAIN: ____
____

DO YOU USE TOBACCO PRODUCTS Y N IF YES:TYPE/AMOUNT/HOW LONG?____________________

DO YOU DRINK ALCOLHOL Y N IF YES:TYPE/AMOUNT/HOW LONG?____________________

DO YOU USE ILLEGAL DRUGS Y N IF YES:TYPE/AMOUNT/HOW LONG____________________

HAVE YOU BEEN EXPOSED TO OR INFECTED WITH: GONORRHEA SYPHILIS HIV HEPATITIS Y N

ACKNOWLEDGMENT OF CORRECT INFORMATION AND FINANCIAL RESPONSIBILTY:

THE INFORMATION HEREBY PROVIDED IS CORRECT TO THE BEST OF MY KNOWLEDGE AND I UNDERSTAND THAT I AM RESPONSIBLE TO PAY FOR THE SERVICES RENDERED. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO RICHARD A BLUE OD FOR SERVICES RENDERED.

SIGNATURE____ DATE________________________