

# Associates In Eyecare Comprehensive Medical History

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Work Phone: \_\_\_\_\_

Birthday: \_\_\_\_\_ Social Security # : \_\_\_\_\_ Last Eye Exam: \_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_ Dr's Phone \_\_\_\_\_

Last Medical Exam: \_\_\_\_\_

## Medical History

Do you have any allergies to medications? no yes If yes, explain: \_\_\_\_\_

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

\_\_\_\_\_

List all major injuries, surgeries and/or hospitalizations you have had: \_\_\_\_\_

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelids, bulging eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: \_\_\_\_\_

\_\_\_\_\_

Are you pregnant and/or nursing? No yes

Do you wear glasses? No yes If yes, how old is your present pair of lenses? \_\_\_\_\_

Do you wear contact lenses no yes If yes, how old is your present pair of lenses? \_\_\_\_\_

Type of contact lenses: gas perm soft extended wear other Are your lenses comfortable? Yes no

## Family History

Please note any family history (parents, grandparents, brothers, sisters, children; living or deceased) for the following:

Disease/Condition	NO	YES	?	RELATIONSHIP TO YOU
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

*\*Please turn over and complete side two\*(created 5/14/2003)*

# Review of Systems

Do you currently, or have you ever had any problems in the following areas:

System	NO	YES ?		NO	YES ?
Constitutional			Ears, Nose, Mouth, Throat		
Fever, Weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (skin)	<input type="checkbox"/>	<input type="checkbox"/>	Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>
Neurological			Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Post-nasal drip	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Eyes			Respiratory		
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/halos	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	Vascular/Cardiovascular		
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Dryness of eyes	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal		
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Foreign body sensation	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary		
Excess tearing/watering	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/kidney/bladder	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Bones/Joints/Muscles		
Eye pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection eye/lid	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic/Hematologic		
Tired eyes	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine			Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/other glands	<input type="checkbox"/>	<input type="checkbox"/>	Allergic/Immunologic	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>			

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

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**Social History:** (the following information is kept strictly confidential. If you prefer only to discuss this information with the doctor directly check the following box.  yes discuss with doctor only

Do you Drive? No yes    If yes, do you have vision problems when driving? No yes    If yes, please explain:

Do you use tobacco? No yes    If yes, type/how much/how long: \_\_\_\_\_

Do you drink alcohol? No yes    If yes, type/how much/how long: \_\_\_\_\_

Do you use Illegal Drugs? No yes    If yes, type/how much/how long: \_\_\_\_\_

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Dr. Signature or Initials \_\_\_\_\_ Date \_\_\_\_\_