Name_____ Date: _____/_____/_____

Occupation _____ Last Medical Exam: _____/_____/_____

MEDICAL HISTORY: List all major injuries, surgeries and/or hospitalizations you've had:

_____

_____

Circle any of the following you've had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye surgery, chronic eye infections or eye injury.

Are you pregnant or nursing? No ☐ Yes ☐

Do you wear glasses? No ☐ Yes ☐

If yes, how old is your current pair of lenses? _____

Do you wear contact lenses? No ☐ Yes ☐

If yes, how old is your current pair of lenses? _____

FAMILY HISTORY: *Please note any family history (parents, grandparents, siblings or children (living or deceased):*

			Relationship to You
Blindness	No ☐	Yes ☐	_____
Cataract	No ☐	Yes ☐	_____
Crossed Eyes	No ☐	Yes ☐	_____
Glaucoma	No ☐	Yes ☐	_____
Macular Degeneration	No ☐	Yes ☐	_____
Retinal Detachment	No ☐	Yes ☐	_____
Retinal Disease	No ☐	Yes ☐	_____
Arthritis	No ☐	Yes ☐	_____
Cancer	No ☐	Yes ☐	_____
Diabetes	No ☐	Yes ☐	_____
Heart Disease	No ☐	Yes ☐	_____
High Blood Pressure	No ☐	Yes ☐	_____
Kidney Disease	No ☐	Yes ☐	_____
Lupus	No ☐	Yes ☐	_____
Thyroid Disease	No ☐	Yes ☐	_____

SOCIAL HISTORY *(all information is kept strictly confidential.)*

Do you drive? No ☐ Yes ☐

Do you:

Drink alcohol? No ☐ Yes ☐ If yes, what frequency? _____

Use tobacco? No ☐ Yes ☐ If yes, what frequency/how long? _____

Use illegal drugs? No ☐ Yes ☐ If yes, type/frequency/how long? _____

Please check the appropriate box if you have been exposed to or infected with the following:

☐ Gonorrhea ☐ Hepatitis _____A _____B _____C ☐ HIV ☐ Syphilis

****DO YOU HAVE OR HAVE YOU EVER BEEN DIAGNOSED WITH MRSA****

(methicillin-resistant Staphylococcus aureus)

YES ☐ NO ☐

OVER

REVIEW OF SYSTEMS: Do you currently, or have you ever had any problems with the following:

	YES	NO
Constitutional		
Fever, Weight loss/gain	☐	☐
Skin Disorders	☐	☐
Neurological		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Eyes		
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distorted Vision/Halos	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy/Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing/Watering	☐	☐
Glare/Light Sensitivity	☐	☐
Eye Pain or Soreness	☐	☐
Chronic Infection Eye/Lid	☐	☐
Sties or Chalazion	☐	☐
Flashes in Vision	☐	☐
Floaters in Vision	☐	☐
Tired Eyes	☐	☐
Endocrine		
Thyroid/Other Glands	☐	☐

	YES	NO
Ears, Nose, Mouth, Throat		
Allergies/Hay fever	☐	☐
Sinus Congestion	☐	☐
Runny Nose	☐	☐
Postnasal Drip	☐	☐
Chronic Cough	☐	☐
Dry Throat/Mouth	☐	☐
Respiratory		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
Vascular/Cardiovascular		
Diabetes	☐	☐
Heart Pain	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
Gastrointestinal		
Diarrhea	☐	☐
Constipation	☐	☐
Genitals/Kidney/Bladder	☐	☐
Bones/Joints/Muscles		
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
Lymphatic/Hematologic		
Anemia	☐	☐
Bleeding Problems	☐	☐
Allergic/Immunologic	☐	☐
Psychiatric	☐	☐

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

_____

_____

_____

_____