***MEDICAL HISTORY INFORMATION***

Date\_\_\_\_/\_\_\_\_/\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First MI Last

Height \_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_ Eye Color \_\_\_\_\_\_\_\_\_ Last Eye Exam \_\_\_\_/\_\_\_\_/\_\_\_\_\_ Doctor’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_ Ethnicity /Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Doctor Last Medical Visit

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Circle all the conditions or symptoms YOU have experienced: (ROS)**

**Constitution:** Fever Weight Gain / Loss

**Cardiovascular:** Heart Disease Angina High Blood Pressure Irregular Heart Beat Blood Clots

**Ear/Nose/Throat:** Hearing Loss Dry Mouth Sinus Problems Sore Throat

**Respiratory:** Asthma COPD Chronic Bronchitis Pneumonia

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**Gastrointestinal:** Constipation Diarrhea Acid Reflux Crohn’s Disease GERD

**Genitourinary:** Kidney Disease Prostrate Disease Urinary infections Kidney Infections

**Musculoskeletal:** Arthritis Osteoporosis Muscle / Joint Pain Multiple Sclerosis

**Dermatological:** Skin Cancer Eczema Dry Skin /Hair /Nails Dermatitis

**Neurological:** Headaches Migraines Seizures Stroke

**Psychiatric:** Depression Panic Disorder Anxiety Dementia Bipolar

**Endocrine:** Diabetes Thyroid Disease Adrenal Gland Disorder Hypoglycemia

**Hematologic/Lymphatic:** Anemia Leukemia Lymphoma Bleeding Disorders

**Allergic / Immunologic:** HIV Positive Lupus Severe Allergies Immune Disorders

**Cancer: (Type)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you Diabetic? Yes No If Yes, Type I or Type II Do you take Insulin Yes No**

**What was your fasting blood sugar?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What was your last HbA1C?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**PATIENT’S Past or Present Ocular History (Circle Yes or No) (PFSH)**

Glaucoma Yes No Blindness Yes No Eye Injury Yes No

Cataracts Yes No Crossed Eyes Yes No Lupus Yes No

Macular Degen Yes No Diabetes Yes No Rheumatoid Yes No

Arthritis

Retinal Disease Yes No Dry Eyes Yes No

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**Family’s Medical History Relationship Relationship**

Glaucoma Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cataracts Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blindness Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amblyopia Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Crossed Eyes Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diabetes Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Disease Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Macular Degen Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Retinal Disease Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cancer Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Page 2 of 2**

**SURGICAL HISTORY (Please list all surgeries and dates)**

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**Communicable Disease History:**

**Have you ever been exposed to or infected with:**

Gonorrhea Yes No Syphilis Yes No

Hepatitis Yes No Tuberculosis Yes No

HIV Yes No Chlamydia Yes

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**MEDICATIONS: List ALL Medications you currently take including over the counter medications and vitamins.**

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**Social History**

**Tobacco Use:** Type Amount How Long

Do you use Tobacco Products? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use recreational drugs? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Circle Yes or No)**

Are you PREGNANT OR NURSING? YES NO

Do you wear glasses? YES NO How old are your glasses?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear contact lenses? YES NO Type/ Name of Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drive? Yes No Any trouble driving at night Yes No

Do you use a computer, cell phone? Yes No How many hours per day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have prescription sunglasses? Yes No Do you need them? Yes No

Do you have prescription safety glasses? Yes No Do you need them? Yes No

What are your hobbies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_