Patient Name: _____ Date of Birth: ____/____/____

MEDICAL HISTORY

Primary Care Physician Name: _____ **City:** _____

EYE HISTORY - past and present

- ☐ Cataract
- ☐ Blurred Vision Near
- ☐ Blurred Vision Distance
- ☐ Amblyopia (Lazy Eye)
- ☐ Color Blindness
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Retinal Detachment
- ☐ Dryness
- ☐ Eye Pain or Soreness
- ☐ Itching
- ☐ Burning
- ☐ Drooping Eyelid
- ☐ Glasses
- ☐ Surgery: _____
- ☐ Other: _____
- ☐ Tired Eyes
- ☐ Glare/Light Sensitivity
- ☐ Redness
- ☐ Infection of Eye or Lid
- ☐ Excess Tearing/Watering
- ☐ Foreign Body Sensation
- ☐ Strabismus (Crossed Eyes)
- ☐ Sandy or Gritty Feeling
- ☐ Distorted Vision (Halos)
- ☐ Double Vision
- ☐ Floaters or Spots
- ☐ Fluctuating Vision
- ☐ Loss of Vision or Side Vision
- ☐ Flashes of Light
- ☐ Refractive Surgery
- ☐ Contact Lenses

GENERAL HEALTH - past and present

- ☐ Diabetes
- ☐ Headaches
- ☐ Head Trauma
- ☐ Allergies
- ☐ Asthma
- ☐ Seizures
- ☐ Muscles, Bones, Joints
- ☐ Anxiety or Depression
- ☐ Cancer: _____
- ☐ Lung Disease
- ☐ Heart Disease
- ☐ Arthritis
- ☐ Vascular Disease
- ☐ High Blood Pressure
- ☐ Lupus
- ☐ Skin Disease
- ☐ Blood/Lymph
- ☐ Shingles
- ☐ Other: _____

FAMILY

- ☐ Amblyopia
- ☐ Blindness
- ☐ Color Blindness
- ☐ Retinal Detachment
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Other: _____
- ☐ Strabismus
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney disease
- ☐ Stroke
- ☐ Arthritis

All Medications: (including non-prescription and vitamins)

_____

_____

Allergies: _____

_____

Date & Reviewed by: **(office use only)**

_____

_____