Today's Date:_____
MR#_____

Personal Health History

Patient Name:_____Occupation:_____DOB:_____Age:_____

Please explain your present eye health and vision condition (if known):

☐ YES ☐ NO **Do you normally wear glasses or contacts?**
If YES, which do you wear most of the time? ☐ Glasses ☐ Contacts
If YES, how old is the prescription?_____

☐ YES ☐ NO **Do you have a history of any eye disease, eye surgery (including laser surgery) or eye injuries?**
If YES, please list types and dates:

☐ YES ☐ NO **Are your currently taking medications of any type (including vitamins and supplements)?**
If YES, please list:

☐ YES ☐ NO **Are you allergic to any medications?**
If YES, please list medications and type of reaction:

☐ YES ☐ NO Not Applicable **Are you now pregnant or breast feeding?**

Medical History: (check box YES or NO. If YES, also note date when first diagnosed.)

	Date		
☐ YES	_____	☐ NO	**High Blood Pressure**
☐ YES	_____	☐ NO	**Diabetes**
☐ YES	_____	☐ NO	**Heart Diabetes (congestive heart failure, heart rhythm problem, heart attack, murmur), Type: _____**
☐ YES	_____	☐ NO	**Lung Disease (emphysema, asthma), Type: _____**
☐ YES	_____	☐ NO	**Liver Disease, Type: _____**
☐ YES	_____	☐ NO	**Kidney Disease, Type: _____**
☐ YES	_____	☐ NO	**Gastrointestinal Disease (Crohn's, ulcerative colitis, peptic ulcer), Type: _____**
☐ YES	_____	☐ NO	**Cancer, Type: _____**
☐ YES	_____	☐ NO	**Stroke or TIA's**
☐ YES	_____	☐ NO	**High Cholesterol**
☐ YES	_____	☐ NO	**Thyroid Disease**
☐ YES	_____	☐ NO	**Migraines**
☐ YES	_____	☐ NO	**Sleep Apnea**
☐ YES	_____	☐ NO	**Seizures**
☐ YES	_____	☐ NO	**Blood/Bleeding Disorder (anemia, blood transfusion), Type: _____**
☐ YES	_____	☐ NO	**Arthritis, Type:_____**
☐ YES	_____	☐ NO	**Emotional Illness (anxiety, depression)**
☐ YES	_____	☐ NO	**Cerebral Palsy**
☐ YES	_____	☐ NO	**Prematurity**

Please list any other medical problems that you have been diagnosed with:_____

☐YES ☐NO **Have you ever had any surgery (not on your eyes)?**
If YES, please list types and dates:

☐YES ☐NO **Do you smoke cigarettes or use tobacco products?**
☐NO, NOT ANY LONGER
If YES, how much or how many cigarettes per day?_____

☐YES ☐NO **Do you drink alcohol?**
☐OCCASIONALLY

☐YES ☐NO **Are you interested in contact lenses?**

☐YES ☐NO **Are you interested in laser vision correction?**

Is there a family history of the following?
(Check box YES or NO. If YES, also note relationship: father, mother, etc.)

☐YES	☐NO	**Cataracts**	☐YES	☐NO	**Macular Degeneration**
☐YES	☐NO	**Glaucoma**	☐YES	☐NO	**Crossed or lazy eye**
☐YES	☐NO	**Retinal Disease**	☐YES	☐NO	**Migraine Headaches**
☐YES	☐NO	**Diabetes**	☐YES	☐NO	**High Blood Pressure**
☐YES	☐NO	**Other:_____**	☐YES	☐NO	**Blindness or tumor/cancer of the eye**

Review of Systems: Do you have any of the following symptoms now?
If NO, Please check box. If YES, please circle all words that apply.

☐NO	**General:**	fever, chills, weight loss, night sweat, scalp tenderness
☐NO	**Ears, Nose, Throat:**	ear pain, facial pain, chronic cough, dry mouth, sneezing
☐NO	**Eye:**	pain, blurred vision, double vision, redness, burning, itching, discharge, light sensitivity, flashing lights, floaters
☐NO	**Heart:**	chest pain, rapid heart beat, high blood pressure
☐NO	**Respiratory:**	shortness of breath, difficulty breathing, discolored sputum, wheezing, congestion
☐NO	**Digestive:**	constipation, nausea, vomiting, blood in stools, black tarry stools, diarrhea, upset stomach
☐NO	**Genital, Kidney:**	increased urinary frequency, pain with urination, impotence
☐NO	**Muscle:**	pain in joints, pain in muscles, stiffness, swelling, cramps
☐NO	**Skin:**	rash, bruising, pimples, warts, growths, redness, itching, hives, swelling
☐NO	**Neuro:**	dizziness, weakness, numbness, tingling, trouble speaking, bowel/bladder dysfunction, loss of balance, headache
☐NO	**Psychiatric:**	Anxiety, depression, insomnia

If you answered yes to any of the above questions and are not currently receiving care for these symptoms, report them to your family physician as soon as possible.

When did you have your last complete physical exam?

Approximate Date:_____Family Doctor's name:_____
Please sign and date: (first and last name)

Signature_____Date_____