

# MEDICAL HISTORY

Name \_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Guardian (if applicable) \_\_\_\_\_ Occupation \_\_\_\_\_  
 Birthdate \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Last Eye Exam \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Do you have vision insurance?  No  Yes If yes, insurance carrier \_\_\_\_\_  
 Do you have health insurance?  No  Yes If yes, insurance carrier \_\_\_\_\_  
 Do you have medicare?  No  Yes

## Medical History

Do you have any allergies to medication?  No  Yes If yes, explain \_\_\_\_\_

List 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 eyelid, glaucoma, cataracts, retinal disease, 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:  Rigid  Soft  Extended Wear  Other Are they comfortable?  No  Yes

## Family History

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

Disease/Condition	No	Yes	?	Relationship
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<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"/>	_____