

Patient Name _____

VISION INFORMATION

Date of last eye exam		Doctor
Have you had eye surgery?		Yes <input type="checkbox"/> No <input type="checkbox"/>
DATE	EYE	PROCEDURE

GENERAL HEALTH INFORMATION

Name of physician	
City	State

FAMILY HISTORY – CHECK ANY THAT APPLY

Father – F Mother – M Brother – B Sister – S
Grandfather – GF Grandmother – GM

	F	M	B	S	GF	GM
Diabetes						
High blood pressure						
Cataracts						
Glaucoma						
Blindness						
Color blindness						
Crossed eyes						
Retinal problems						
Macular degeneration						
Other ocular problems						

Are you taking any medication? Yes ☐ No ☐

EYE MEDICATIONS	PURPOSE
OTHER MEDICATIONS	PURPOSE

Do you have any drug allergies? Yes ☐ No ☐

DRUG ALLERGIES

MEDICAL HISTORY – CHECK ANY THAT APPLY

EYE		ENDOCRINE		GASTROINTESTINAL		CONSTITUTIONAL	
	Glaucoma		Diabetes (non-insulin dependent)		Crohns		Developmental disability
	Cataract		Diabetes (insulin dependent)		Colitis		Weight loss
	Macular degeneration		Thyroid dysfunction		Ulcer		Fever
	Surgery		Hormonal dysfunction		Digestive/acid reflux		Fatigue
	Inflammatory disorders		Other		Other		Trauma
	Other	CARDIOVASCULAR		PSYCHIATRIC			Other
RESPIRATORY			Heart disease		Depression	DERMATOLOGY	
	Cigarette smoker		Hypertension		Panic Disorder		Eczema
	Asthma		Stroke		Schizophrenia		Rosacea
	Bronchitis		Vascular Disease		Other		Psoriasis
	Emphysema		Other	EARS, NOSE & THROAT			Other
	Other	ALLERGIC/IMMUNOLOGIC			Upper respiratory tract infection	NEUROLOGICAL	
MUSKULOSKELETAL			Drug allergy				Multiple sclerosis
	Fibromyalgia		Environmental allergy		Other		Epilepsy
	Muscular dystrophy		Rheumatoid arthritis	GENINTOURINARY			Other
	Osteoarthritis		Lupus		STD		
	Rheumatoid arthritis		HIV		Viral herpetic, chlamydia		
	Other		Other		Other		