Name: ______________________________ Birth Date: ____/____/______ Today's Date: ______/______/______

Past Medical History

List your current medications: ☐ None ____

____

____

Are you allergic to any medication? ☐ No ☐ Yes **(List):** ______________________________

List major illness, injury, or surgery: ____

List eye illness, injury, or surgery: ____

Date of last eye examination: _____/_____/_____ Doctor/Clinic: _________________________

Do you wear glasses? ☐ No ☐ Yes Age of your current lenses? _______

Do you wear contacts? ☐ No ☐ Yes Age of your current lenses? _______ Type of Contacts: _________________

Have you had LASIK? ☐ No ☐ Yes Are you interested in LASIK? ☐ No ☐ Yes

Review of Systems (Do you currently have or have you ever had any problems in the following areas?)

EYES				**RESPIRATORY**			
Blurred Vision	☐ No	☐ Yes	________	Asthma	☐ No	☐ Yes	________
Loss of Vision	☐ No	☐ Yes	________	Emphysema	☐ No	☐ Yes	________
Double Vision	☐ No	☐ Yes	________	**VASCULAR**			
Floaters	☐ No	☐ Yes	________	High Blood Pressure	☐ No	☐ Yes	________
Flashes	☐ No	☐ Yes	________	Heart Disease	☐ No	☐ Yes	________
Dry Eyes	☐ No	☐ Yes	________	**GASTRIC**			
Redness	☐ No	☐ Yes	________	Intestinal Disease	☐ No	☐ Yes	________
Excess Tearing	☐ No	☐ Yes	________	**GENITOURINARY**			
CONSTITUTION				Bladder Infection	☐ No	☐ Yes	________
Weight Loss/Gain	☐ No	☐ Yes	________	Kidney Disease	☐ No	☐ Yes	________
SKIN DISEASE	☐ No	☐ Yes	________	**BONES/JOINTS**			
NEUROLOGIC				Rheumatoid Arthritis	☐ No	☐ Yes	________
Headaches	☐ No	☐ Yes	________	**LYMPHATIC**			
Seizures	☐ No	☐ Yes	________	Swollen Gland/Node	☐ No	☐ Yes	________
ENDOCRINE				**IMMUNOLOGIC**			
Thyroid	☐ No	☐ Yes	________	Lupus	☐ No	☐ Yes	________
Diabetes	☐ No	☐ Yes	________	**PSYCHIATRIC**			
EARS/NOSE				Depression	☐ No	☐ Yes	________
Sinus Infection	☐ No	☐ Yes	________	**OTHER**			________

Family History (Please note any family history for the following conditions & list their **relationship** to you)

Blindness	☐ No	☐ Yes	________	Diabetes	☐ No	☐ Yes	________
Cataract	☐ No	☐ Yes	________	High Blood Pressure	☐ No	☐ Yes	________
Glaucoma	☐ No	☐ Yes	________	Heart Disease	☐ No	☐ Yes	________
Macular Degeneration	☐ No	☐ Yes	________	Cancer	☐ No	☐ Yes	________
Retinal Detachment	☐ No	☐ Yes	________	Kidney Disease	☐ No	☐ Yes	________
Crossed/Lazy Eye	☐ No	☐ Yes	________	Thyroid Disease	☐ No	☐ Yes	________
Keratoconus	☐ No	☐ Yes	________	Arthritis	☐ No	☐ Yes	________

Social History (This information is kept strictly confidential)

Are you: ☐ Married ☐ Divorced ☐ Widowed ☐ Single

Have you ever been exposed to or infected with:

☐ HIV ☐ Syphilis ☐ Hepatitis ☐ Gonorrhea ☐ None

Do you use tobacco? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes

Do you use illegal drugs? ☐ No ☐ Yes

Doctor's Signature: ______________________________ Date: ______________________

FOR OFFICE USE ONLY (Change in Medical History) ______________________________

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