Medical History Form

Name: _____ Date of Birth: _____ Sex: M☐ F☐

Current Medical Doctor and Location: _____

Reason for today's visit (circle all that apply): Glasses / Contact Lenses / Eye Health Exam / Other

Past Ocular History

Last Eye Exam: _____ Age of Current Eyewear: _____

Eye Medications: _____

History of Eye Trauma, Surgery, or Other: _____

Past and Present Medical History

Medical Allergies: _____

Environmental Allergies: _____

Current Medications: _____

_____

Previous Surgeries: _____

Medical Conditions

	You Yes	You No
Abdominal Problems	❒	❒
Blood/Bleeding Disorders	❒	❒
Cancer (*type:*_____)	❒	❒
Ear, Nose, Mouth, Throat	❒	❒
Fever/Weight Loss	❒	❒
Genital/Urinary	❒	❒
Muscle/Bone/Joint	❒	❒
Nervous System Disorder	❒	❒
Psychological Disorder	❒	❒
Respiratory	❒	❒
Thyroid	❒	❒
Other (please describe)	❒	❒
Pregnant or nursing?	❒	❒

	You Yes	You No	Family (if yes, who?) Yes	Family (if yes, who?) No
Blindness	❒	❒		❒ _____
Cataracts	❒	❒		❒ _____
Crossed or lazy eyes	❒	❒		❒ _____
Glaucoma	❒	❒		❒ _____
Macular Degeneration	❒	❒		❒ _____
Retinal Detachment	❒	❒		❒ _____
Diabetes	❒	❒		❒ _____
Heart Disease	❒	❒		❒ _____
High Blood Pressure	❒	❒		❒ _____
High Cholesterol	❒	❒		❒ _____

*Please describe any "**yes**" below*

_____

Social History	Yes
Alcohol Use	❒
Tobacco Use	❒
Drug Use	❒
Home assistance	❒

(*if yes* ❒ current ❒ former)

(*if yes, type*:_____)

Signature: _____ Date: _____

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