Patient Name:_____Birth Date:___/____/_____Sex:□ Male □ Female Date:____/____/_____
Phone #_____Social Security# (Both parents if under 18)_____
Family Doctor/Phone #_____/_____Do you have? □ Medicaid □ Medicare □ other
e-mail: @

Medical History

LIST your medications, vitamins, supplements, eye drops, birth control…Lists can be photocopied at your request. □Attached

□**None**

MARK if you have (or are treated for) any of the following; add additional where needed.

Allergies
□NONE
□ sulfa
□ penicillin
□ codeine
□ drops used at an eye exam
□ LATEX
□ seasonal
□Other(explain)_____

Eye
□NONE
□ redness
□ pain
□ discharge
□ unexplained blur
□ glaucoma
□ macular or retinal_____
□ cataract surgery
□LASIK/PRK/RK…_____
□ history of eye surgery_____
□Other(explain)_____

Endocrine
□NONE
□ diabetes T 1 or 2 since_____YR
□ thyroid_____
□ hepatitis type____/Liver_____
□Other(explain)_____

Females:
If **Pregnant**, Due Date:_____
If **Nursing**, Delivery Date:_____

Respiratory
□NONE
□ asthma
□ bronchitis
□ lung cancer
□Other(explain)_____

Muscle/Bone/Joint
□NONE
□ rheumatoid arthritis
□ lupus
□ sarcoidosis
□Other(explain)_____

Cardiovascular
□NONE
□ high cholesterol
□ high blood pressure
□ irregular heartbeat
□ heart attack
□ stroke or TIA
□Other(explain)_____

Blood/Lymph
□NONE
□ HIV
□Other(explain)_____

Digestive
□NONE
□Other(explain)_____

Skin/Integumentary
□NONE
□Other(explain)_____

Neurological
□NONE
□ learning disability_____
-Developmental Age_____
□ autism_____
□ migraines or headaches
□Other(explain)_____

Psychiatric
□NONE
□ depression
□ anxiety
□Other(explain)_____

Ear/Nose/Mouth/Throat
□NONE
□ hearing impaired or deaf
□Other(explain)_____

Genital/Urinary
□NONE
□ STI/STD_____
□ Kidney_____
□Other(explain)_____

Other
□NONE
□ weight gain
□Other(explain)_____

Explain **any hospitilizations** in the past 5yrs
_____
_____
_____
_____

Family History

High Blood Pressure *No / sibling / parent / grandparent*
Diabetes *No / sibling / parent / grandparent*
Glaucoma *No / sibling / parent / grandparent*
Macular Degeneration *No / sibling / parent / grandparent*
Other (explain)_____

Social History

Hobbies, Interests, Activities:_____
Occupation/Student:_____
□ Alcohol □ Tobacco □ Marijuana
Previous Illegal Drug use? (explain)_____

Reason for your examination today (circle all that apply)

*Contact Lenses / Blurred Vision / Dry or Watery Eyes / Itching or Burning Eyes / Eye Injury / Eye Infection / Glasses / Computer Glasses / Sunglasses / Eye Health Evaluation / Other (explain)*_____

Office Use Only Doctor Signature:_____, OD Date____/____/_____