Medical History Form

Name_____ Date____/____/____
Address_____ Phone_____
City_____ State_____ Zip_____ Cell_____
Parent/Guardian (if applicable)_____ Email_____
Birthdate____/____/____ Last Eye Exam____/____/____ Occupation_____

Medical History Primary Care Doctor_____

List all medications you take (including oral contraceptives, aspirin, over-the-counter medications, and home remedies)

List all Medical Conditions you have been diagnosed with and date of diagnosis (Example: High Blood Pressure 2012)

Circle any of the eye conditions you have been diagnosed with:
macular degeneration inflammatory disorder cataract strabismus/lazy eye keratoconus amblyopia
glaucoma surgery patching eye injury retinal degeneration/hole/detachment
other_____

Are you pregnant or nursing? No Yes
Do you wear glasses? No Yes if yes, how old is your current pair of lenses?_____
Do you wear contact lenses? No Yes if yes, what brand?_____ How often do you replace them?_____
Circle type of contact lens? Rigid Soft Scleral Do you sleep, shower, or swim in your lenses? No Yes

Family History

Note any family history for the following conditions: Relationship

Thyroid Disease	No Yes	
Diabetes	No Yes	
High blood pressure	No Yes	
High Cholesterol	No Yes	
Cancer	No Yes	
Lazy Eye	No Yes	
Cataract	No Yes	
Glaucoma Suspect	No Yes	
Amblyopia	No Yes	
Degenerative Myopia	No Yes	
Macular Degeneration	No Yes	
Retinal Detachment/Disease	No Yes	
Glaucoma	No Yes	
Severe Hyperopia	No Yes	
Other	No Yes	

Social History

Do you drive? No Yes
Do you have visual difficulty when driving? No Yes
Do you use tobacco? No Yes
if yes, type/amount/how long

Do you drink alcohol? No Yes
if yes, type/amount/ how long

Do you use illegal drugs? No Yes
if yes, type/amount/how long

Would you rather discuss this privately with the doctor? No Yes

Surgical History list all surgeries and year performed (Ex. Appendectomy 2012)

Height____ft _____inches

Weight_____pounds

Doctor Use

BMI_____