Patient History

Please check if any apply

Allergic/ Immunologic

- ☐ Drug Allergy_____
- ☐ Environmental
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Other_____

Gastrointestinal

- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Digestive
- ☐ Other_____

Psychiatric

- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Other_____

Endocrine

- ☐ Non Insulin Dependent Diabetic
- ☐ Insulin Dependent Diabetic
- ☐ Thyroid
- ☐ Hormonal
- ☐ Other_____

Eyes

- ☐ Glaucoma
- ☐ Cataract
- ☐ Macular Degeneration
- ☐ Surgery
- ☐ Inflammatory Disorders
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Flashes or Floaters
- ☐ Crossed or Lazy Eye
- ☐ Other_____

Neurological

- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Alzheimer's
- ☐ Parkinson's
- ☐ Cerebrovascular
- ☐ Other_____

Genitourinary

- ☐ STD, Viral Herpetic, Chlamydia
- ☐ Other_____

Social

- ☐ Pregnant/Nursing
- ☐ Drink Alcohol
- ☐ Other Substances

Ears, Nose & Throat

- ☐ Upper Respiratory Infection
- ☐ Ear Ache
- ☐ Runny Nose
- ☐ Sore Throat
- ☐ Ringing/ Tinitis
- ☐ Other_____

Integumentary

- ☐ Eczema
- ☐ Rosacca
- ☐ Psoriasis
- ☐ Other_____

Musculoskeletal

- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Ankylosing Spondylitis
- ☐ Other_____

Constitutional

- ☐ Developmental Disability
- ☐ Weight Loss
- ☐ Fever
- ☐ Fatigue
- ☐ Trauma
- ☐ Other_____

Hematologic/Lymphatic

- ☐ Anemia
- ☐ Large Volume Blood Loss
- ☐ Leukemia
- ☐ Other_____

Cardiovascular

- ☐ Heart Disease
- ☐ Hypertension
- ☐ Stroke
- ☐ Vascular Disease
- ☐ Other_____

Respiratory

- ☐ Current Smoker
- ☐ Former Smoker
- ☐ Never Smoker
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Other_____

Family Ocular & Medical History

- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Cataract
- ☐ Hypertension
- ☐ Diabetes
- ☐ Cerebrovascular
- ☐ Other_____

Date of last Eye Exam?
_____

Do you wear or have glasses?
Yes or No

Do you wear contacts?
Yes or No

Are you interested in trying contacts? Yes or No

Do you have visual difficulty when driving? Yes or No

Is it okay to dilate your eyes?
Yes or No

Are you currently involved in any hobbies, sports, work environments, or live in an environment that may cause eye strain or harm to your vision? Yes or No

Please List:
_____
_____

Name of your primary doctor:
_____

Name of your pharmacy:
_____

Please list eye drops that you use: _____

Please list any daily medications and vitamins you are currently taking or prescribed (include dosage, frequency, and how you take it) If you have a list we can copy them.

_____
_____
_____
_____
_____
_____
_____