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

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

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