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____/____/________