MEDICAL HISTORY **YOUR NAME:** **TODAY'S DATE:**

CHIEF COMPLAINT AND HISTORY OF PRESENT ILLNESS-Why are you here today?

List all eye health problems/symptoms*:____________________
*Medical insurance will only cover if there is a medical reason for the exam such as loss of vision, headaches, eye redness, eye pain, eye itching, glaucoma, cataracts, floaters, dry eyes, etc.

Please answer the following by circling:

Location	**Which eye has the problem?**	Right eye – Left eye – Both eyes
Quality	**Does the problem cause vision loss or blur?**	Loss – Blur
Context	**Did the problem occur suddenly or gradual?**	Sudden – Gradual
Severity	**How severe is the problem?**	Mild – Moderate – Severe
Modifying Factors	**Is it worse at any specific distance?**	Distance – Near –Computer
Duration	**How long does the problem last?**	Intermittent – Constant
Timing	**How long has the problem been occurring?**	Short term – Long term
Associated Symptoms	**Are there associated symptoms?**	No – Headache – Pain - Light Sensitivity – Other____________
Previous Interventions	**Does anything help the problem?**	Nothing helps – Nothing has been tried-Other______________

PAST, FAMILY AND/OR SOCIAL HISTORY- Please answer the following. Please write NA, if it does not apply. **(1, 3)**

Personal Medical History:
Have you had any major illnesses, injuries, or operations? [ ] Y [ ] N Explain:____________________
Are you taking any medications (prescription and over-the-counter)? [ ] Y [ ] N List: ____________________
____
Date of Last Medical Exam: ______________ Doctor: __________________________ For women: Pregnant/nursing? [ ] Y [ ] N

Family Health History: Please circle any condition in your family history and indicate relative affected.

Glaucoma	_____________	Corneal Problem	______________	Diabetes	______________
Macular Degen	_____________	Crossed eyes	______________	Heart Disease	______________
Retinal Problem	_____________	Lazy eye	______________	High Blood Pressure	______________

Social History: Your occupation/grade: ________________________ Place of employment/school:________________________
List your sports, hobbies, or special visual needs:____________________
How many hours do use a computer a day? _____ Have you been exposed to Herpes, HIV, TB, Hepatitis? [ ] Y [ ] N ________
Do you use tobacco products? [ ] Y [ ] N Do you drink alcohol? [ ] Y [ ] N Do you use recreational drugs? [ ] Y [ ] N
Please list all family members in your household: _______________________ age:_____ ____________________age:_____
____________________________age:_____ _______________________ age:_____ ____________________age:_____

REVIEW OF SYSTEMS – Check inside the boxes if you have a problem with any of the following: **(1, 2, 10)**

Eyes	**Y**	**N**
Loss of vision	[ ]	[ ]
Blurred vision	[ ]	[ ]
Double vision	[ ]	[ ]
Cataracts	[ ]	[ ]
Crossed eyes	[ ]	[ ]
Flashes	[ ]	[ ]
Floaters	[ ]	[ ]
Dry eyes	[ ]	[ ]
Watery eyes	[ ]	[ ]
Red eyes	[ ]	[ ]
Mucous discharge	[ ]	[ ]
Burning or itching	[ ]	[ ]
Sandy or gritty feeling	[ ]	[ ]
Eye pain or soreness	[ ]	[ ]
Light sensitivity	[ ]	[ ]
Chronic eye infections	[ ]	[ ]
Tired eyes/Eyestrain	[ ]	[ ]
Halos/Glare	[ ]	[ ]
Previous Vision Therapy	[ ]	[ ]
Previous Eye surgery	[ ]	[ ]
Previous Eye injury	[ ]	[ ]
Retinal detachment	[ ]	[ ]
Glaucoma	[ ]	[ ]

If you answered yes to eye injury or eye surgery, please explain :
____
____

Allergic/Immunologic	**Y**	**N**
Hay fever/Allergies	[ ]	[ ]
Medicine allergies	[ ]	[ ]
Lupus	[ ]	[ ]
Sjogrens	[ ]	[ ]
Constitutional symptoms		
Fever	[ ]	[ ]
Recent Weight loss	[ ]	[ ]
Cardiovascular		
Heart disorder	[ ]	[ ]
High blood pressure	[ ]	[ ]
Vascular disease	[ ]	[ ]
Ears, Nose, Mouth, Throat		
Sinus problems	[ ]	[ ]
Dry throat/mouth	[ ]	[ ]
Chronic ear infections	[ ]	[ ]
Endocrine		
Diabetes	[ ]	[ ]
Thyroid problems	[ ]	[ ]
Other glands	[ ]	[ ]

If you answered YES to high blood pressure, what was your last blood pressure measurement? ______________

If you answered YES to diabetes, when were you diagnosed? _________________
List your last Blood Sugar: ____________
List your last Hemoglobin A1C: _________

Genitourinary	**Y**	**N**
Genitals	[ ]	[ ]
Kidneys or Bladder	[ ]	[ ]
Hematologic/Lymphatic		
Anemia	[ ]	[ ]
High cholesterol	[ ]	[ ]
Integumentary		
Skin	[ ]	[ ]
Breast	[ ]	[ ]
Musculoskeletal		
Arthritis	[ ]	[ ]
Rheumatoid Arthritis	[ ]	[ ]
Muscle pain/Joint pain	[ ]	[ ]
Neurological		
Headaches	[ ]	[ ]
Migraines	[ ]	[ ]
Seizures	[ ]	[ ]
Multiple Sclerosis	[ ]	[ ]
Psychiatric		
Nervous disorders	[ ]	[ ]
Depression	[ ]	[ ]
Respiratory		
Asthma	[ ]	[ ]
Shortness of breath	[ ]	[ ]
Emphysema	[ ]	[ ]
Lung cancer	[ ]	[ ]

List any other medical conditions not listed above:______________________________

__________ OD ☐ No Change _______Date _________, OD ☐ No Change ________Date _________, OD ☐ No Change ________Date