Medical History

Patient Name:_____ **Date:**_____

Family of General Physician's
Name:_____

Currently Taken Medications (RX or over the counter) YES OR NO (list):
_____

Allergic to any Medications? YES OR NO (list):
_____

Do you have any problems in the following areas?

(Please circle YES or NO and if "other" explain).

YES NO **Allergy** (Hay Fever, Sulfa Drugs, Foods or other)	YES NO **Hematologic, Blood/Lymph** (Anemia, Leukemia, Cancer or other)
YES NO **Cardiovascular** (High Blood Pressure, High Cholesterol or other)	YES NO **Immunologic** (Lupus, Herpes, HIV, Sjogrens or other)
YES NO **Constitutional** (Constant Dizziness, Long-Term Fatigue or other)	YES NO **Integumentary (Skin)** (Acne, Warts, Skin Cancer or other)
YES NO **Endocrine** (Diabetes, Hypothyroid, Hyperthyroid or other)	YES NO **Musculoskeletal (Muscles, Bones, Joints)** (Arthritis, Osteoporosis or other)
YES NO **Gastrointestinal** (Stomach ulcers, Acid Reflux, or other)	YES NO **Neurological** (Multiple Sclerosis, Migraines or other)
YES NO **Genitourinary (Genitals, Kidney, Bladder)** (STD's, Bladder Infections, Prostate or other)	YES NO **Psychiatric** (Anxiety, Depression, Bipolar or other)
YES NO **Ears, Nose, Mouth, Throat (Sinus Trouble, Ear Infections or other)**	YES NO **Respiratory** (Asthma, Emphysema, COPD or other)

YES NO Do you use tobacco products?
YES NO Do you drink alcohol?

Glaucoma _____
Diabetes _____
High Blood Pressure _____
Other: _____

Do you have any of the following?

Burning	Uncomfortable glasses
Itchiness	Sudden loss of vision
Watery Eyes	Blurry distance vision
Double Vision	Blurry near vision
Flashes of Light Glaucoma	Eye Disease/ Infection Eye Injury
Glare or Reflection Eye Injury	Gritty feeling in eyes Dryness
Soreness Redness	Trouble seeing at night Sensitivity to light
Eye Strain Headaches	Eye Surgery Other

VISUAL NEEDS

Work at a computer for long periods of time? Do work requiring safety glasses?	Want information on lineless bifocals? Have problems with glare or reflections (ex: night driving)?
Have only one pair of glasses?	Participate in sports / hobbies? What? _____
Want information on thinner, lighter lenses?	Want more information about corrective vision surgery?
Scratch your glasses easily? Do work requiring safety glasses?	Want to change the color of your eyes? Wear or ever tried wearing contacts? What kind? _____
Want information on lineless bifocals? Prefer not to wear your glasses at times?	Spend a lot of time outdoors? Are your eyes sensitive to sunlight?