Patient Medical/Eye History

Name: Date:

Reason for today's visit: _____

Is the reason for your visit due to an injury at work? _____ Accident?: _____

Have you ever had an eye injury or eye surgery? Please Check One: YES :_____ NO:_____

Have you ever had double vision, floaters or flashes? YES:_____ NO:_____

Describe any headaches that you have on a regular basis: _____

Please list any/all current medications, eye drops, vitamins, or supplements: _____

_____

_____

_____

_____

Medication allergies/sensitivities: _____

Environmental allergies/sensitivities: _____

Do you wear contact lenses: YES:____ NO:____ Do you wear eye glasses: YES: ____ NO: ____

Do your eyes: ITCH:_____ BURN: _____ Do you have any EYE PAIN? YES: ____ NO: _____

For **you** or any **blood relative**, is there a history of: (Please check and explain who)

Glaucoma: _____ Cataracts: _____ Macular Degeneration: _____

Retinal Disease/Detachment: _____ Crossed/Lazy Eye: _____ Other: _____

Do **YOU** have a history of:

Diabetes: ____ Hypertension: _____ Heart Disease: _____ Thyroid: _____ Sinusitis: _____

Asthma/Respiratory Disease: _____ Arthritis: _____ Multiple Sclerosis:_____ Systemic Lupus: _____

Crohn's Disease: ____ Bladder/Kidney Disease: _____ Migraines: _____ Seizures: _____ Anxiety: ____

Bleeding/Anemia: ____ Cancer: _____ (if so, what type) HIV/AIDS: _____ Cholesterol: _____

Other medical conditions: _____

Are you currently:

Pregnant/Nursing: YES: _____ NO: _____ A smoker: YES: _____ NO: _____

Patient Signature: _____ Date: _____