## Medical History

Name_____Date_____/_____/_____

Address _____Phone_____

City_____ State _____ Zip_____ Cell _____

Guardian (if applicable)_____Email_____

Birthdate _____/_____/_____ Last Eye Exam _____/_____/_____ Occupation_____

Do you have vision insurance? ❒ No ❒Yes If yes, insurance carrier

_____

Do you have health insurance? ❒ No ❒Yes If yes, insurance carrier

_____

Do you have Medicare? ❒ No ❒Yes

## Medical History

List medications you take (including oral contraceptives, aspirin, over-the-counter medications, and home remedies)

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_____

_____

_____

_____

_____

Check any of the following that you have had:

❒ age-related macular degeneration ❒ inflammatory disorder ❒ cataract ❒ strabismus

❒ kerataconus ❒ amblyopia ❒ glaucoma suspect ❒ glaucoma ❒ surgery

❒ retinal degeneration/hole/detachment ❒ patching ❒ eye injury

Name_____Date_____/_____/_____

Are you pregnant and/or nursing? ❒ No ❒ Yes

Do you wear glasses? ❒ No ❒ Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ❒ No ❒ Yes If yes, what brand? _____

Type of contact lenses: ❒ Rigid ❒ Soft ❒ Extended Wear ❒ Other Are they comfortable? ❒ No ❒ Yes

## Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

| Disease/Condition | Yes/No/? | Relationship |
|---|---|---|
| Thyroid Disease | ❒ ❒ ❒ | _____ |
| Diabetes | ❒ ❒ ❒ | _____ |
| Hypertension | ❒ ❒ ❒ | _____ |
| Cancer | ❒ ❒ ❒ | _____ |
| Strabismus | ❒ ❒ ❒ | _____ |
| Cataract | ❒ ❒ ❒ | _____ |
| Glaucoma Suspect | ❒ ❒ ❒ | _____ |
| Amblyopia | ❒ ❒ ❒ | _____ |
| Severe Myopia | ❒ ❒ ❒ | _____ |
| Macular Degeneration | ❒ ❒ ❒ | _____ |
| Retinal Detachment/Disease | ❒ ❒ ❒ | _____ |
| Glaucoma | ❒ ❒ ❒ | _____ |
| Severe Hyperopia | ❒ ❒ ❒ | _____ |
| Other | ❒ ❒ ❒ | _____ |

Name_____Date_____/_____/_____

**Social History** – This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❒ Yes, I prefer to discuss my Social History information directly with the doctor.

Do you drive? ❒ No ❒ Yes If yes, do you have visual difficulty when driving? ❒ No ❒ Yes If yes, please describe:

_____

_____

_____

Do you use tobacco products? ❒ No ❒ Yes If yes, type/amount/how long

_____

Are you a ❒ Former Smoker ❒ Current Occasional Smoker ❒ Current Everyday Smoker

Do you drink alcohol? ❒ No ❒ Yes If yes, type/amount/how long

_____

Do you use illegal drugs? ❒ No ❒ Yes If yes, type/amount/how long

_____N

**Review of Systems** Do you currently, or have you ever had, any problems in the following areas:

| **Eyes** | **Yes/ No** | **Yes/No** | | | **Yes/No** |
|---|---|---|---|---|---|
| Itching | ❒ ❒ | Diplopia | ❒ ❒ | Burning | ❒ ❒ |
| Mattering | ❒ ❒ | Loss of Vision | ❒ ❒ | Photophobia | ❒ ❒ |
| Red | ❒ ❒ | Floaters | ❒ ❒ | Loss of Sharpness | ❒ ❒ |
| Flashes | ❒ ❒ | Tearing | ❒ ❒ | | |

Other_____

Beyond Eye Care P.L.L.C.

Name_____Date_____/_____/_____

| Constitutional | Yes/No |
|---|---|
| Developmental Disorders | ❒ ❒ |
| Cancer | ❒ ❒ |
| Fatigue Syndrome | ❒ ❒ |
| Other_____ | |

| Ear, Nose, Mouth, Throat | Yes/No |
|---|---|
| Sinusitus | ❒ ❒ |
| Dry Mouth | ❒ ❒ |
| Hearing Loss | ❒ ❒ |
| Laryngitis | ❒ ❒ |
| Other_____ | |

| Neurological | Yes/No |
|---|---|
| Epilepsy | ❒ ❒ |
| Multiple Seizures | ❒ ❒ |
| Tumor | ❒ ❒ |
| Cerebral Palsy | ❒ ❒ |
| Stroke/CVA | ❒ ❒ |
| Migraine | ❒ ❒ |
| Other_____ | |

| Psychiatric | Yes/No |
|---|---|
| Depression | ❒ ❒ |
| Bipolar | ❒ ❒ |
| Anxiety | ❒ ❒ |
| Attention Deficit | ❒ ❒ |
| Other_____ | |

| Vascular/Cardiovascular | Yes/No |
|---|---|
| Vascular Disease | ❒ ❒ |
| Stroke | ❒ ❒ |
| Heart Disease | ❒ ❒ |
| High Blood Pressure | ❒ ❒ |
| Congestive Heart Failure | ❒ ❒ |
| Other_____ | |

| Respiratory | Yes/No |
|---|---|
| Cigarette Smoker | ❒ ❒ |
| Bronchitis | ❒ ❒ |
| COPD | ❒ ❒ |
| Emphysema | ❒ ❒ |
| Asthma | ❒ ❒ |
| Sleep Apnea | ❒ ❒ |
| Other_____ | |

Beyond Eye Care P.L.L.C.

Name_____Date_____/_____/_____

| Genitourinary | Yes/No |
|---|---|
| Kidney Disease | ❒ ❒ |
| STD - Herpetic/Chlamydia | ❒ ❒ |
| Prostate Disease/Cancer | ❒ ❒ |
| Pregnant/Nursing | ❒ ❒ |

Other_____

| Endocrine | Yes/No |
|---|---|
| Diabetes Type II | ❒ ❒ |
| Thyroid Dysfunction | ❒ ❒ |
| Hormonal Dysfunction | ❒ ❒ |
| Diabetes Type I | ❒ ❒ |

Other_____

| Musculoskeletal | Yes/No |
|---|---|
| Arthritis | ❒ ❒ |
| Ankylosing Spondylitis | ❒ ❒ |
| Fibromyalgia | ❒ ❒ |
| Muscular Dystrophy | ❒ ❒ |
| Osteoarthritis | ❒ ❒ |

Gout ❒ ❒

Other_____

| Integumentary | Yes/No |
|---|---|
| Herpes Simplex/Cold Sores | ❒ ❒ |
| Herpes Zoster/Shingles | ❒ ❒ |
| Rosacea | ❒ ❒ |
| Psoriasis | ❒ ❒ |
| Eczema | ❒❒ |

Other_____

| Hematologic/Lymphatic | Yes/No |
|---|---|
| Large Volume Blood Loss | ❒ ❒ |
| Anemia | ❒ ❒ |
| Ulcer | ❒ ❒ |
| High Cholesterol | ❒ ❒ |

Other_____

| Allergic/Immunologic | Yes/ No |
|---|---|
| Environmental Allergies | ❒ ❒ |
| Lupus | ❒ ❒ |
| Rheumatoid Arthritis | ❒ ❒ |
| Drug Allergies | ❒ ❒ |

If yes, what drug?_____

Sjogrens Syndrome ❒ ❒

Other_____

Beyond Eye Care P.L.L.C.

Name_____Date_____/_____/_____

| **Gastrointestinal** | **Yes/No** | | **Yes/No** |
|---|---|---|---|
| Crohn's Disease | ❒ ❒ | Celiac Disease | ❒ ❒ |
| Ulcer | ❒ ❒ | Crohn's Disease | ❒ ❒ |
| Acid Reflux | ❒ ❒ | Colitis | ❒ ❒ |

Other_____

If you answered yes to any of the above, or have a condition not listed, please explain:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____