PATIENT MEDICAL HISTORY

LAST OPTOMETRIST: ___________________________________ LAST VISION EXAM: _______________

PRIMARY CARE PHYSICIAN:____________________________ LAST MEDICAL EXAM:______________

CURRENT MEDICATIONS:____

MEDICAL ALLERGIES:____

Allergies
Seasonal Allergies ___
Itchy Eyes ___
Chronic Sinus Infections ___

Neurological
Frequent Headaches ___
Migraines ___
Past Head Trauma ___

Medical History
Hypertension ___
Diabetes ___
High cholesterol ___
Asthma ___
Arthritis ___
Thyroid Condition ___
Stroke ___
Other_______________________

PATIENT VISION HISTORY

Eye Muscle Issues
Lazy Eye ___
Prism in Glasses ___
Double Vision ___
Past Vision Therapy ___

Optical
Problems with Glare ___
Work on computer ___
Outdoor Sports ___
Problems Driving at night ___

Eye Health History
Glaucoma ___
Cataracts ___
Past Eye Surgery ___
Floaters/Flashes ___
Retinal Detachment ___
Macular Degeneration ___
Dry Eyes ___
Watery Eyes ___
Other: _____________________

Contact Lens History
Current Brand of contacts:______________
Do you sleep in them?____ Frequency:____
Do you have back-up glasses?_______
Any problems with vision or comfort?_____

Ocular Family History

Family history of Glaucoma ___ Relative(s)___________________________
Family history of Blindness ___ Relative(s)___________________________
Family history of Retinal Detachment ___ Relative(s)___________________________
Family history of Macular Degeneration ___ Relative(s)___________________________
Family history of Lazy or crossed eyes ___ Relative(s)___________________________