Medical History for Vision Wellness Center

Name ____ Today's Date _____/_____/______

Address ___________________________ City/Zip _______________ Phone _________________

Birthday ______/_____/______ Social Security # ______/_____/______ Last Eye Exam_______/________

Name of Medical Doctor ____________________________ Last Medical Exam _______/________

Medical History
Do you have any allergies to medications? ( ) no ( ) yes If yes, what? ___________________________

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

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____

List any major injuries, surgeries and/or hospitalizations you have had ______________________________

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List any of the following that you have had: crossed eyes, lazy eyes, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injuries: ________________________________

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Are you pregnant and/or nursing? ( )no ( )yes
Do your wear glasses? ( ) no ( ) yes If yes, how old are your present pair of glasses? _________________
Do you wear contact lenses? ( ) no ( ) yes If yes, how old are your present pair of lenses? _______________
Type of contact lenses ( ) oxygen permeable ( ) soft ( )extended wear ( ) other Comfortable? ( ) no ( ) yes

Family History
Please note any family history (parents, grandparents, siblings, children; living or deceased)

DISEASE / CONDITION	NO	YES	?	Relationship to you
Blindness	( )	( )	( )	______________________________
Cataract	( )	( )	( )	______________________________
Crossed Eyes	( )	( )	( )	______________________________
Glaucoma	( )	( )	( )	______________________________
Macular Degeneration	( )	( )	( )	______________________________
Retinal Detachment/Disease	( )	( )	( )	______________________________
Arthritis	( )	( )	( )	______________________________
Cancer	( )	( )	( )	______________________________
Diabetes	( )	( )	( )	______________________________
Heart Disease	( )	( )	( )	______________________________
High Blood Pressure	( )	( )	( )	______________________________
Kidney Disease	( )	( )	( )	______________________________
Lupus	( )	( )	( )	______________________________
Thyroid Disease	( )	( )	( )	______________________________
Other _____________	( )	( )	( )	______________________________

Please turn this form over and complete side two

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with doctor.

( ) Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

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

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

Do you drink alcohol? ( ) Yes ( ) No If yes, type/amount/how long __________________________________

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

Have you ever been exposed to or infected with: ( ) Gonorrhea ( ) Hepatitis ( ) HIV ( ) Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL	( )	( )	( )
Fever, Weight Loss/Gain	( )	( )	( )
INTEGUMENTARY (skin)	( )	( )	( )
NEUROLOGICAL			
Headaches	( )	( )	( )
Migraines	( )	( )	( )
Seizures	( )	( )	( )
EYES			
Loss of Vision	( )	( )	( )
Blurred Vision	( )	( )	( )
Distorted Vision/Halos	( )	( )	( )
Loss of Side Vision	( )	( )	( )
Double Vision	( )	( )	( )
Dryness	( )	( )	( )
Mucous Discharge	( )	( )	( )
Redness	( )	( )	( )
Sandy or Gritty Feeling	( )	( )	( )
Itching	( )	( )	( )
Burning	( )	( )	( )
Foreign Body Sensation	( )	( )	( )
Excess Tearing/Watering	( )	( )	( )
Glare/Light Sensitivity	( )	( )	( )
Eye Pain or Soreness	( )	( )	( )
Chronic Infection eye/lid	( )	( )	( )
Styes or Chalazion	( )	( )	( )
Flashes/Floaters in Vision	( )	( )	( )
Tired Eyes	( )	( )	( )
ENDOCRINE			
Thyroid/Other glands	( )	( )	( )
PSYCHIATRIC	( )	( )	( )

	NO	YES	?
EAR, NOSE, MOUTH, THROAT	( )	( )	( )
Allergies/ Hay Fever	( )	( )	( )
Sinus Congestion	( )	( )	( )
Runny Nose	( )	( )	( )
Post-Nasal Drip	( )	( )	( )
Chronic Cough	( )	( )	( )
Dry Throat/Mouth	( )	( )	( )
RESPIRATORY			
Asthma	( )	( )	( )
Chronic Bronchitis	( )	( )	( )
Emphysema	( )	( )	( )
VASCULAR/CARDIOVASCULAR			
Diabetes	( )	( )	( )
Heart Pain	( )	( )	( )
High Blood Pressure	( )	( )	( )
Vascular Disease	( )	( )	( )
GASTROINTESTINAL			
Diarrhea	( )	( )	( )
Constipation	( )	( )	( )
GENITOURINARY			
Genitals/Kidney/Bladder	( )	( )	( )
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	( )	( )	( )
Muscle Pain	( )	( )	( )
Joint Pain	( )	( )	( )
LYMPHATIC/HEMATOLOGIC			
Anemia	( )	( )	( )
Bleeding Problems	( )	( )	( )
ALLERGIC/IMMUNOLOGIC	( )	( )	( )

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

Doctor's Signature Date