Medical History Sheet

Patient's Name_____

Primary reason for today's visit:_____

List any medications/eye drops you currently use (or attach a list to this sheet):_____
_____

List any allergies to medications_____

List any major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc) or injuries (concussion, etc.)_____
_____

List any surgeries you have had (cataract, LASIK, tonsillectomy, appendectomy, etc.) & approximate date:_____
_____

Do you currently wear contacts?_____ Have you tried contacts?_____ Do you currently wear glasses?_____

*Do you presently have any problems in the following areas? If **yes**, please explain

Eyes	**YES**	**NO**	**Details**
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Glare or light sensitivity			
Visual difficulty when driving			
Problems with night vision			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing or watering			
Eye pain or soreness			
Tired eyes			
Crossed eyes / lazy eye			

Patient's History	**YES**	**NO**	**Details**
Cardiovascular (high blood pressure, racing pulse, etc)			
Gastrointestinal (stomach / Intestines)			
Musculoskeletal (muscles / joints)			
Neurological (numbness, headache, etc)			
Endocrine (hormones, glands, etc)			
Seasonal allergies (hay fever, etc)			

Family History (not yourself)	**YES**	**NO**	**Relationship to Patient**			**YES**	**NO**	**Relationship to Patient**
Age macular degeneration					Glaucoma			
Arthritis					High blood pressure			
Blindness					Heart disease			
Cancer					Thyroid disease			
Cataract					Stroke			
Diabetes					Other			

Patient's Signature_____ Date_____

Physician's Signature_____ Date_____