Couple of Eyes Vision Care, P.C.
Medical History Form

Name: Today's Date: ___________________
Last eye exam:__________________

History of Present Illness

Do you wear glasses? Y N How old are your current glasses?________
Do you wear contacts? Y N How often do you dispose of your contacts?
Do you wear sunglasses? Y N ____________________________________

Do **you** currently experience…

□	Loss of vision	□	Blurry vision
□	Fluctuating vision	□	Distorted vision
□	Loss of side vision	□	Double vision
□	Dry eyes	□	Mucus discharge
□	Excessive tearing or watery eyes	□	Gritty eyes/foreign body sensation
□	Itchy eyes or eyelids	□	Red eyes
□	Glare or light sensitivity	□	Eye pain or soreness
□	Eyelid discomfort/stye	□	Tired eyes
□	Flashes or floaters in vision	□	Crossed/lazy eyes
□	Seasonal allergies	□	Other________________________

Please explain:____
____
____
____
____

Occupation:__________________________
How many hours a day are you in front of a computer? _______ cellphone/tablet?______
Watch TV? _____________Driving?____________
List your special interests or hobbies? ____
Do you have difficulty with 3D movies or VR games? Y N
Do you have difficulty driving at night or while raining? Y N

Medical History

Name of Primary Care Physician:______________________ Last medical exam:______

History of Surgeries/Injuries:___________________________________

Drug allergies:____

List of medications:____

____

Review of Systems
Please list and explain any past or current conditions:

Psychological (anxiety, depression, ADHD) ______________________________
Constitutional (fever, weight loss/gain) ______________________________
Neurological (migraines, seizures, MS) ______________________________
Vascular (diabetes, heart pain, hypertension) ______________________________
Endocrine (thyroid disease, pituitary disease) ______________________________
Immune (Lupus, Sjogrens, allergies) ______________________________
Genito-Urinary (kidney/ prostate disease, ulcers) ______________________________
Muscles/Bones/Joints (arthritis, muscle/joint pain) ______________________________
Lymph/Blood (anemia, high cholesterol, bleeding) ______________________________
Respiratory (asthma, bronchitis, emphysema) ______________________________
Ears/Nose/Throat (sinus/ear infection, dry mouth) ______________________________
Gastrointestinal (diarrhea, stomach ulcers) ______________________________
Skin (acne rosecea, skin cancer, alopecia) ______________________________

Family History

Do any blood relatives have… If so, Who?

- □ Diabetes ______________________________
- □ Heart disease ______________________________
- □ Hypertension ______________________________
- □ Kidney disease ______________________________
- □ Thyroid disease ______________________________
- □ Arthritis ______________________________
- □ Lupus ______________________________
- □ Cancer ______________________________
- □ Blindness ______________________________
- □ Glaucoma ______________________________
- □ Macular degeneration ______________________________
- □ Cataract ______________________________
- □ Strabismus ______________________________
- □ Retinal detachment/disease ______________________________
- □ Other ______________________________

Social History

Do you use recreational drugs? Y N
Do you use tobacco products? Y N
Do you drink alcohol? Y N
Are you currently pregnant or nursing? Y N

Signature __________________________________ **Date** _____________