17-047-D-JWCo.

# Medical and Ocular History

Patient's Name________________________________________________Date of birth_______________________________

**Do you have any allergies to medications? If yes, please list**_______________________________________________

**List all medications you currently take** (including eye drops, oral contraceptives, aspirin, vitamins and supplements)

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Personal Medical History**

Do you currently have or have ever had any of the following conditions? Check those that apply.

**General Health**
- ❒ Currently Pregnant or Nursing
- ❒ Developmental Disability
- ❒ Cancer - Type________________
- ❒ Tobacco Use
  Type__________Amount_______
- ❒ Alcohol Use
  Type__________Amount_______
- ❒ Drug Use

**Allergic/Immunologic**
- ❒ Environmental Allergies
- ❒ Chronic Sinus Congestion/Cough
- ❒ Lupus / Rheumatoid Arthritis

**Cardiovascular**
- ❒ Hypertension/High Blood Pressure
- ❒ Stroke
- ❒ Heart Disease
- ❒ High Cholesterol

**Endocrine**
- ❒ Diabetes
- ❒ Hypothyroid / Hyperthyroid

**Gastrointestinal**
- ❒ Crohns / Colitis / Ulcer
- ❒ Other___________________

**Respiratory**
- ❒ Asthma
- ❒ Emphysema
- ❒ Chronic Bronchitis

**Eyes**
- ❒ Retinal Detachment/Disease
- ❒ Glaucoma/Optic nerve disorder
- ❒ Cataracts
- ❒ Macular Degeneration
- ❒ Lazy/Crossed Eye
- ❒ Corneal Disease
- ❒ Eye Injury
- ❒ Eye Allergies
- ❒ Prism In glasses
- ❒ Double Vision
- ❒ Dry Eyes

**Dermatologic**
- ❒ Eczema
- ❒ Rosacea
- ❒ Psoriasis

**Musculoskeletal**
- ❒ Muscular Dystrophy
- ❒ Osteoarthritis
- ❒ Ankylosing Spondylitis
- ❒ Fibromyalgia

**Hematologic/Lymphatic**
- ❒ Bleeding Problems
- ❒ Leukemia
- ❒ Anemia

**Genitourinary**
- ❒ Kidney or Bladder Disease
- ❒ Other__________________

**Psychiatric**
- ❒ Depression
- ❒ Anxiety
- ❒ Other ________________

**Neurological**
- ❒ Multiple Sclerosis
- ❒ Seizures
- ❒ Head Trauma
- ❒ Headaches/Migraines

**Infectious Disease**
- ❒ AIDS/HIV
- ❒ Hepatitis
- ❒ Tuberculosis
- ❒ STDs__________________

**Other Health Conditions**
- ❒ ________________________

Have you had any major ocular injuries or surgeries? Please list them.

______________________________________________________________________________

______________________________________________________________________________

**Family History**

Does any family member (parents, grandparents, siblings, or children) currently have or had any of the following conditions? Please write the relationship to you.

- ❒ Blindness __________________________________
- ❒ Cataract___________________________________
- ❒ Retinal Detachment_________________________
- ❒ Glaucoma__________________________________
- ❒ Macular Degeneration_______________________
- ❒ High Blood Pressure________________________________
- ❒ Diabetes__________________________________________
- ❒ Thyroid Disease___________________________________
- ❒ Cancer___________________________________________
- ❒ Heart Disease_____________________________________

**HISTORY REVIEW** For Office Use only

Provider/Tech______ Date__________ Provider/Tech______ Date __________ Provider/Tech_____ Date_________
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