Medical and Ocular History

17-047-D-JWCo.

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_____

Provider/Tech_____ Date_____ Provider/Tech_____ Date _____ Provider/Tech_____ Date_____

Provider/Tech_____ Date_____ Provider/Tech_____ Date _____ Provider/Tech_____ Date_____