

MEDICAL HISTORY

Name _____ Date _____ / _____ / _____
 Address _____ Phone _____
 City _____ State _____ Zip _____ Work Phone _____
 Guardian (if applicable) _____ Occupation _____
 Birthdate _____ / _____ / _____ Last Eye Exam _____ / _____ / _____

Do you have vision insurance? No Yes If yes, insurance carrier _____
 Do you have health insurance? No Yes If yes, insurance carrier _____
 Do you have medicare? No Yes

Medical History

Do you have any allergies to medication? No Yes If yes, explain _____

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

List all major injuries, surgeries, and/or hospitalizations you have had _____

List any of the following that you have had – crossed eyes, lazy eye, drooping eyelid, glaucoma, cataracts, retinal disease, eye infections, or eye injury _____

Are you pregnant and/or nursing? No Yes
 Do you wear glasses? No Yes If yes, how old is your present pair of lenses? _____
 Do you wear contact lenses? No Yes If yes, how old is your present pair of lenses? _____
 Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? No Yes

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

| Disease/Condition | No | Yes | ? | Relationship |
|----------------------------|--------------------------|--------------------------|--------------------------|--------------|
| Blindness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cataract | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Crossed Eyes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Macular Degeneration | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Retinal Detachment/Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Lupus | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Thyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Name _____ Date _____/_____/_____

Social History – This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I prefer to discuss my Social History information directly with the doctor.

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

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

Do you drink alcohol? No Yes If yes, type/amount/how long _____

Do you use illegal drugs? No Yes 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:

| | No | Yes | ? | | No | Yes | ? |
|---------------------------------|--------------------------|--------------------------|--------------------------|---------------------------------|--------------------------|--------------------------|--------------------------|
| Constitutional | | | | Ear, Nose, Mouth, Throat | | | |
| Fever, Weight Loss/Gain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Allergies/Hay Fever | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Integumentary | | | | Sinus Congestion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Skin | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Runny Nose | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Neurological | | | | Post-Nasal Drip | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic Cough | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Migraines | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dry Throat/Mouth | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory | | | |
| Eyes | | | | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blurred Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Distorted Vision/Halos | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vascular/Cardiovascular | | | |
| Loss of Side Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Double Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dryness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mucous Discharge | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vascular Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Redness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gastrointestinal | | | |
| Sandy or Gritty Feeling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Itching | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic Constipation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Burning | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Genitourinary | | | |
| Foreign Body Sensation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Genitals/Kidney/Bladder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Excess Tearing/Watering | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bones/Joints/Muscles | | | |
| Glare/Light Sensitivity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye Pain or Soreness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscle Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic Infection of Eye or Lid | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Joint Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sties or Chalazion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lymphatic/Hematologic | | | |
| Flashes/Floaters in Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tired Eyes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Endocrine | | | | Allergic/Immunologic | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid/Other Glands | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

Doctor's Signature _____

Date _____/_____/_____

Dr. Balski Dr. Mocanu Other _____