Name: ____ Date: _____________________________

Medical/ Ocular History

Past Ocular History:

	Yes	No		Yes	No
None/ Unremarkable	☐	☐	Dry Eyes	☐	☐
Cataracts	☐	☐	Amblyopia/ Lazy eye	☐	☐
Glaucoma	☐	☐	Surgery/ Other: ________________________		
Macular Degeneration	☐	☐	______________________________________		
Retinal/ detachment	☐	☐	______________________________________		

Past Medical/ Surgical History

	Yes	No		Yes	No
None/ Unremarkable	☐	☐	Cancer (type:__________)	☐	☐
High blood pressure	☐	☐	Heart disease	☐	☐
Diabetes: Type 1/ Type 2	☐	☐	Surgery/ Other: ________________________		
High cholesterol	☐	☐	______________________________________		
Thyroid (hypo/ hyper)	☐	☐	______________________________________		

Medication with strength: (Including vitamins):

____ ______________________________________

____ ______________________________________

____ ______________________________________

Preferred Pharmacy: _____________________ Phone #: _____________________________________

Mail Order Pharmacy: _____________________ Phone #: _____________________________________

Allergies: ____

Family Ocular/ Medical History: Indicate family member

None/ Unremarkable

Diabetes __________________

Glaucoma _________________

Amblyopia/ lazy eye _________

Blindness __________________

Cataract ______________________

Hypertension__________________

Macular Degeneration___________

Retinal detachment ____________

Social History:

Alcohol Use: None ☐ Moderate ☐ Mild ☐ Heavy ☐

Tobacco Use: None ☐ Type: _____________

Frequency/ Amount: ___________________________

Name: ____ Date: ____________________________

Review of Systems: Do you have these now? If so circle condition and explain.

Yes	No	
☐	☐	**Allergy:** Seasonal/ Year rough: ____
		____
☐	☐	**Cardiovascular:** High/ Low blood pressure/ chest pain/ irregular beat
		____
☐	☐	**Constitutional:** Fever/ weight change/ fatigue ____________________________
		____
☐	☐	**Endocrine:** High sugar/ High thyroid/ low thyroid __________________________
		____
☐	☐	**ENT:** Hearing loss/ sinus ____
		____
☐	☐	**Eye:** Blurred vision/ eye pain/ flashes/ floaters ____________________________
		____
☐	☐	**GI:** Abdominal Pain/ nausea/ vomiting/ diarrhea __________________________
		____
☐	☐	**GU:** FLOMAX use/ groin pain/ sores ____
		____
☐	☐	**Blood:** Anemia/ easy bruising/ swollen lymph nodes ________________________
		____
☐	☐	**Skin:** Rashes/ changing moles/ eczema __________________________________
		____
☐	☐	**Musculoskeletal:** Joint pain/ weakness/ back pain __________________________
		____
☐	☐	**Neurological:** Headache/ scalp tenderness/ jaw pain ______________________
		____
☐	☐	**Psychiatric:** Anxiety/ depression ____
		____
☐	☐	**Respiratory:** Shortness of breath/ Sleep apnea/ CPAP ______________________