MEDICAL HISTORY FORM

Patient Name_____ Date of Birth _____
Email_____ Phone Number_____
Would you like to be contacted by ☐Telephone ☐Postal ☐Email
Family Physician_____ Insurance_____
Hobbies_____ Primary Language_____ Race/Ethnicity_____
Employer_____ Occupation_____
How long ago was your last eye exam?_____ How old are your glasses?_____
Do you have any questions or concerns you would like to discuss with the doctor? ☐ No ☐ Yes
Please describe below:_____
_____

Do you experience any…

Routine headaches?	☐ No	☐ Yes
Double vision?	☐ No	☐ Yes
Flashes of light?	☐ No	☐ Yes
Floaters?	☐ No	☐ Yes
Do you use eye drops?	☐ No	☐ Yes

If YES, what kind?_____

Contact Lenses

Do you NOW wear contact lenses?	☐ No	☐ Yes
Have you EVER worn contact lenses?	☐ No	☐ Yes
If "NO", are you interested in wearing them?	☐ No	☐ Yes

How many hours/day do you wear your contacts ?_____
What solution do you use for disinfection? _____
Are you happy with your current contacts? ☐ No ☐ Yes
Interested in trying something new today? ☐ No ☐ Yes

Medical History

Are you Currently taking any Medications (prescription, over the counter, vitamins)? ☐ No ☐ Yes
If YES, what do you take and what are they used for? (use back if necessary).
_____
_____
Are you Allergic to any Medications? ☐ No ☐ Yes
If YES, please list_____
_____

Do you… Use Tobacco Products? ☐ Never ☐In the past: when did you quit?_____ ☐Currently: what/how much?_____
Drink Alcohol? ☐ No ☐ Yes how much?_____
Use Recreational Drugs? ☐ No ☐ Yes

Do you or any BLOOD RELATIVES now have, or have you ever been diagnosed with…

OCULAR	**WHO?**	**YES**	**NO**
Glaucoma?		☐	☐
Cataracts?		☐	☐
Macular Degeneration?		☐	☐
Ocular Trauma?		☐	☐
Ocular Surgery?		☐	☐
"Eye Turn" or "Lazy Eye"?		☐	☐
ENDOCRINE	**WHO?**	**YES**	**NO**
Diabetes?		☐	☐
Thyroid Disorder?		☐	☐
CARDIOVASCULAR	**WHO?**	**YES**	**NO**
High blood pressure?		☐	☐
Elevated Cholesterol?		☐	☐
Stroke?		☐	☐
Heart Attack?		☐	☐
NEUROLOGIC	**WHO?**	**YES**	**NO**
Migraines?		☐	☐
Multiple Sclerosis?		☐	☐
Seizures?		☐	☐

IMMUNOLOGIC	**WHO?**	**YES**	**NO**
Rheumatoid arthritis?		☐	☐
Sjogrens?		☐	☐
Lupus?		☐	☐
SKIN DISORDERS	**WHO?**	**YES**	**NO**
Rosacea?		☐	☐
RESPIRATORY	**WHO?**	**YES**	**NO**
Asthma**?**		☐	☐
Allergies?		☐	☐
BLOOD/LYMPHATIC	**WHO?**	**YES**	**NO**
Bleeding Disorder?		☐	☐
Cancer?		☐	☐

What kind? _____
_____

	YES	**NO**
Are you pregnant/nursing?	☐	☐

Any other health issues?_____
_____
_____

Almost finished…don't forget to complete the back before handing in your updated information