PATIENT MEDICAL HISTORY

NAME _____ DATE _____

1. Have you ever been treated for **any medical conditions**? (diabetes, hypertension, arthritis, etc)
   NO ◯ YES ◯ If YES, please list:

2. Have you ever been treated for **any eye disease**? (glaucoma, cataract, lazy eye, retina)
   NO ◯ YES ◯ If YES, please list:

3. Do you take **any** daily **medications**?
   NO ◯ YES ◯ If YES, please list:

   Do you use **any eye drops?**
   NO ◯ YES ◯ If YES, please list:

   Please list **any DRUG allergies:**

Do you have any of the following systemic problems?

	YES	NO
Chronic fever, fatigue, weight loss/gain?	◯	◯
Ear/nose/throat problems?	◯	◯
Heart problems?	◯	◯
Respiratory problems?	◯	◯
Gastrointestinal problems?	◯	◯
Urinary problems?	◯	◯
Skin problems?	◯	◯
Musculoskeletal problems?	◯	◯
Neurological problems?	◯	◯
Psychiatric problems?	◯	◯
Hematological/Lymphatic?	◯	◯
Allergic/Immunologic?	◯	◯

Eye problems?

	YES	NO
Blurred vision/Eyestrain?	◯	◯
Double vision?	◯	◯
Dryness?	◯	◯
Mucous discharge?	◯	◯
Redness?	◯	◯
Burning/Gritty feeling?	◯	◯
Itching/Seasonal allergies?	◯	◯
Tearing/Watering	◯	◯
Glare/Light sensitivity?	◯	◯
Pain/Soreness?	◯	◯
Sties/Chalazion?	◯	◯
Flashes/Floaters?	◯	◯

Do any medical or eye diseases run in your <u>Family</u>?

	YES	NO
Cataracts?	◯	◯
Lazy Eye?	◯	◯
Glaucoma?	◯	◯
Macular degeneration?	◯	◯
Arthritis?	◯	◯
Diabetes?	◯	◯
Heart disease?	◯	◯
Cancer?	◯	◯
Lupus?	◯	◯
Thyroid?	◯	◯
Hypertension?	◯	◯
Retinal detachment/disease?	◯	◯

Additional questions...

	YES	NO
Do you smoke?	◯	◯
Do you drink?	◯	◯
Any infectious disease?	◯	◯
Are you pregnant?	◯	◯
Are you nursing?	◯	◯
Do you drive?	◯	◯
Problems seeing at night?	◯	◯
Excessive glare/halos?	◯	◯

Additional Comments or Concerns

_____

O.D. Signature

Thank You!!! –Doctors Ricart, Villella, Cage