Medical History

1. Name: **Date of Birth:** **Today's Date:**

2. Your Primary Care Doctor's Name: **Medications:**

3. Are you allergic to anything (including medicine) **Your Phone Number / Email Address**

4. Address:

How can we help you today?

Chief Complaint: (Your Medical Insurance will only cover if one of these reasons are circled)

Red Eye / Eye Pain / Loss of Vision / Eye Itching / Eye Burning / Blurriness / Glaucoma / Cataracts / Floating Spots / Dry Eyes / Diabetes / Other

How else can we help you:

(Circle One Please) **Glasses Exam** or **Contact Exam**

History of Present Illness (HPI – circle 4)

Location	Right Eye	or Left Eye	or Both Eyes
Quality	Vision Loss	or Blurry Vision	
Context	Happened Gradually	or Happened Suddenly	
Severity	Mild	or Moderate	or Severe
Modifying Factor	Worse at Distance	or Worse at Near	or Both
Duration	Constant	or Comes and Goes	
Timing	Started Recently	or Started a long time ago	
Previous Intervention	Nothing Helps	or Nothing tried	

Past, Family, and Social History

Is there anything in your past history, family history or social history which would help us care for you? (please circle or check the box for 'None')

Personal History [Diabetes, High Blood Pressure, Cancer, Infectious Diseases, other] or [ ] None

Family History [Diabetes, High Blood Pressure, Cancer, Glaucoma, Macular Degeneration] [ ] None

Social History [Tobacco, Alcohol, Recreational Drugs] [ ] None

Review of System – Do you have a problem with…

Eyes	**Y**	**N**
Blindness	[ ]	[ ]
Loss of Vision	[ ]	[ ]
Distorted Vision	[ ]	[ ]
Blurred Vision	[ ]	[ ]
Cataracts	[ ]	[ ]
Crossed Eyes	[ ]	[ ]
Flashes of Light	[ ]	[ ]
Floating Spots	[ ]	[ ]
Dry Eyes	[ ]	[ ]
Watery Eyes	[ ]	[ ]
Red Eyes	[ ]	[ ]
Mucous Discharge	[ ]	[ ]
Burning or Itching	[ ]	[ ]
Sandy or Gritty Feeling	[ ]	[ ]
Glare/light sensitivity	[ ]	[ ]
Chronic Eye Infection	[ ]	[ ]
Tired Eyes	[ ]	[ ]
Halos	[ ]	[ ]
Vision Therapy	[ ]	[ ]
Eye Surgery	[ ]	[ ]
Eye Injury	[ ]	[ ]
Retinal Detachment	[ ]	[ ]
Glaucoma	[ ]	[ ]

Allergic /Immunogenic	**Y**	**N**
Hay Fever	[ ]	[ ]
Medicine Allergies	[ ]	[ ]
Food Allergies	[ ]	[ ]
Constitutional Symptoms		
Fever	[ ]	[ ]
Weight Loss	[ ]	[ ]
Cardiovascular		
Heart Pain	[ ]	[ ]
High Blood Pressure	[ ]	[ ]
Vascular Disease	[ ]	[ ]
Ears, Nose, Mouth, Throat		
Sinus Problems	[ ]	[ ]
Chronic Cough	[ ]	[ ]
Dry throat/mouth	[ ]	[ ]
Chronic Ear Infections	[ ]	[ ]
Endocrine		
Diabetes	[ ]	[ ]
Thyroid	[ ]	[ ]
Other glands	[ ]	[ ]
Gastrointestinal		
Diarrhea	[ ]	[ ]
Constipation	[ ]	[ ]
Ulcer	[ ]	[ ]

Genitourinary	**Y**	**N**
Genitals	[ ]	[ ]
Kidneys	[ ]	[ ]
Bladder	[ ]	[ ]
Hematologic/Lymphatic		
Anemia	[ ]	[ ]
Bleeding Problems	[ ]	[ ]
Integumentary		
Skin	[ ]	[ ]
Breast	[ ]	[ ]
Musculoskeletal		
Arthritis	[ ]	[ ]
Muscle Pain	[ ]	[ ]
Neurological		
Headaches	[ ]	[ ]
Migraines	[ ]	[ ]
Seizures	[ ]	[ ]
Psychiatric		
Nervous disorders	[ ]	[ ]
Depression	[ ]	[ ]
Compulsive Behavior	[ ]	[ ]
Respiratory		
Asthma	[ ]	[ ]
Emphysema	[ ]	[ ]
Shortness of Breath	[ ]	[ ]