



Date: \_\_\_\_\_

Name \_\_\_\_\_ Birth date: \_\_\_\_\_

**OPTICAL INFORMATION:**

Do you wear glasses? Yes / No How old is the prescription? \_\_\_\_\_  
Do you wear them? \_\_\_\_\_ most of the time; \_\_\_\_\_ just for reading; \_\_\_\_\_ for driving only  
Do you wear contacts? Yes / No How old are your present contacts? \_\_\_\_\_  
What type? \_\_\_\_\_ Hard \_\_\_\_\_ Soft How many hours/days do you wear them? \_\_\_\_\_

**MEDICAL HISTORY:**

**PRIMARY CARE DOCTOR:** \_\_\_\_\_

PRESENT REVIEW OF SYSTEMS (Do you currently have any problems in the following areas)

Constitutional (fever)	Y	N	Bones, joints, muscles		
Weight loss/gain	Y	N	Rheumatoid arthritis	Y	N
Skin	Y	N	Joint Pain	Y	N
Neurological System	Y	N	Endocrine	Y	N
Headaches	Y	N	Diabetes (____ Yrs)	Y	N
Migraines	Y	N	Thyroid	Y	N
Stroke (when____)	Y	N	Cancer (type_____)	Y	N
Ear, Nose, Mouth, Throat	Y	N	Psychiatric	Y	N
Hayfever	Y	N	Allergic/Immunologic	Y	N
Sinus congestion	Y	N	Kidney problems	Y	N
Dry throat/mouth	Y	N	HIV positive	Y	N
Chronic cough	Y	N	Eyes		
Respiratory (lung)	Y	N	Cataracts	Y	N
Chronic bronchitis	Y	N	Glaucoma	Y	N
Asthma	Y	N	Macular degeneration	Y	N
Emphysema	Y	N	Retinal problems	Y	N
Cardiovascular (heart)	Y	N	Sties or Chalazion	Y	N
Heart pain	Y	N	Eye Injury	Y	N
High blood pressure			Vision Loss	Y	N
( ____ ) years	Y	N	Drooping eyelids	Y	N
Poor Circulation	Y	N	Crossed eyes (lazy eye)	Y	N
Gastrointestinal (Stomach)	Y	N	OTHER: _____		

**PAST MEDICAL HISTORY** (list all surgeries & Hospitalizations, including the year)

\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS:** (including oral contraceptives, aspirin, over-the-counter medications, and eye drops)

\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES:** (List all medications that have caused an allergic reaction)  NONE

**FAMILY HISTORY:** (circle and/or list any medical problems in your family)

Glaucoma / diabetes / high blood pressure / crossed eyes / lazy eye / retinal problems / cancer / Arthritis / gout / heart disease / kidney disease / lupus / stroke / thyroid / lung problems

Other: \_\_\_\_\_

**SOCIAL HISTORY:**

Do you use tobacco products? YES / NO How much? \_\_\_\_\_ packs / day  
Do you drink alcohol? YES / NO How much? \_\_\_\_\_ drinks / week

**FOR OFFICE USE:**

EXAM DATE / REVIEWED BY:

EXAM DATE / REVIEWED BY:

\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_