Print Name:____

Ocular and Medical History

Reason for visit____

- Age of glasses_____ ▸ Age of contacts_____ ▸ **Are you interested in ☐contacts or ☐Lasik?**
- **Last eye exam:**____/____/____ ▸ **Dilation: No☐ Yes☐** year?_________ from Dr.________________________
- Do you use the computer? ☐N ☐Y How many hrs/day? ☐1-2hrs ☐2-4hrs ☐4-6hrs ☐6-8hrs ☐8+hrs
- **Current Eyeglasses:** ☐ Distance ☐ Rx Sunglasses ☐ Reading ☐ Computer ☐ Progressives ☐ Bifocals ☐Trifocals
- **Current Contact Lens:** ☐Soft disposables☐ Rigid Gas Permeable ☐ MF Contacts ☐ Monovision ☐ Colored ☐ Astigmatism
- **Height**: ___**ft.**_____**in.** ▸ **Weight**:________**Lbs.**
- **Flu Shot:** Have you had the **current flu shot**? **No**☐ **Yes**☐ Date:_______ **Preferred language spoken**_______

Race:

☐ White
☐ Hispanic
☐ African American
☐ Asian ☐American Indian/Alaskan Native
☐ Native Hawaiian/ Pacific Islander
☐Other_______________ ☐Declined

Ethnicity:

☐Caucasian
☐Mexican/ Latino
☐African American
☐Chinese
☐Other_____________☐Declined

▸ **Do you and / or any of your family members have the following? If yes, please specify what relative.**

	None	Self	Relative		None	Self	Relative
Diabetes	☐	☐	☐ ________	Crossed eyes	☐	☐	☐ ________
High BP	☐	☐	☐ ________	Glaucoma	☐	☐	☐ ________
Heart disease	☐	☐	☐ ________	Cataracts	☐	☐	☐ ________
Thyroid disease	☐	☐	☐ ________	Mac. degen.	☐	☐	☐ ________
Cancer	☐	☐	☐ ________	Retinal disease	☐	☐	☐ ________
Blindness	☐	☐	☐ ________	Other_________	☐	☐	☐ ________

- Are you pregnant and/or nursing? ☐No ☐Yes
- Last physical:___/____/____ ▸ Who is your primary care doctor? Dr. ___________________
- Are you taking any **medications** (prescription/OTC)? ☐No ☐Yes Please list ____________________________

____

- Do you have any **allergies** to medication or other? ☐No ☐Yes Please explain ____________________________

____

Social History & Review of Systems

- **Smoking Status:** ☐ Never a Smoker ☐Former Smoker ☐Current some day smoker ☐Current every day smoker ☐Other (Explain):____
- **Do you drink alcoholic beverages?** ☐ No ☐ Yes If yes, explain.______________________________
- **Do you use illicit drugs?** ☐ No ☐ Yes ▸ **Do you have HIV or AIDS?** ☐ No ☐ Yes

Constitutional	**N**	**Y**	**Vascular/Cardiovascular**	**N**	**Y**	**Gastrointestinal**	**N**	**Y**
Weight Loss	☐	☐	Chest Pain	☐	☐	Diarrhea	☐	☐
Weight Gain	☐	☐	Vascular Disease	☐	☐	Constipation	☐	☐
Fever	☐	☐	High Cholesterol	☐	☐	Ulcer	☐	☐
Integumentary (Skin)			**Endocrine**			Acid Reflux	☐	☐
Rosacea	☐	☐	Hypothryoid	☐	☐	Irritable Bowel Syndrome	☐	☐
Acne	☐	☐	Hyperthyroid	☐	☐	**Genito-urinary**		
Warts	☐	☐	Diabetes	☐	☐	Painful Urination	☐	☐
Rash	☐	☐	**Respiratory**			Frequent Urination	☐	☐
Eyes			Asthma	☐	☐	BPH	☐	☐
Blurred Vision	☐	☐	Chronic Bronchitis	☐	☐	Kidney Stones	☐	☐
Decreased Vision	☐	☐	Emphysema	☐	☐	**Ear, Nose, Throat**		
Light Sensitivity	☐	☐				Sinus Congestion	☐	☐
Double Vision	☐	☐	**Musculoskeletal**			Post-Nasal Drip	☐	☐
Eye Pain/Soreness	☐	☐	Arthritis	☐	☐	Sore Throat	☐	☐
Discharge	☐	☐	Muscle Pain	☐	☐	Tinnitus (Ringing)	☐	☐
Redness	☐	☐	Joint Pain	☐	☐	**Psychiatric**		
Itching/Burning	☐	☐	**Neurological**			Anxiety	☐	☐
Dry Eyes	☐	☐	Headaches/ Migranes	☐	☐	Depression	☐	☐
Flashes/Floaters	☐	☐	Seizures	☐	☐	Insomnia	☐	☐
Prominent Eyes	☐	☐	Paralaysis	☐	☐	ADD/ADHD	☐	☐
Eye injury/Surgery	☐	☐	**Hematologic/Lymphatic**			Bipolar	☐	☐
Other____________			Anemia	☐	☐			
			Bleeding/Bruising	☐	☐			

The information above is true to the best of my knowledge and I understand that it may negatively impact my examination.

Signature:____**Date:**______________________