Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical History : Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

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

Past Surgical History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Past Ocular Surgical History:

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

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

Past Ocular History:

\_\_\_\_\_ Esotropia (eyes cross in) \_\_\_\_\_ Exotropia (eyes drift out)

\_\_\_\_\_ Nasolacrimal duct obstruction \_\_\_\_\_ Poor vision one eye (amblyopia) \_\_\_Right \_\_\_Left

\_\_\_\_\_ Myopia (near sightedness) \_\_\_\_\_ Hyperopia (far sighted)

\_\_\_\_\_ Astigmatism \_\_\_\_\_ Anisometropia (different focus each eye)

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

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

Family History:

\_\_\_\_\_ strabismus (eyes cross/drift) \_\_\_\_\_ poor vision one eye (amblyopia)

\_\_\_\_\_ Cataract as child/young adult \_\_\_\_\_ Cataract as adult/elderly

\_\_\_\_\_ Glaucoma \_\_\_\_\_ Myopia (near sighted)

\_\_\_\_\_ Migraine Headaches \_\_\_\_\_ Nystagmus (constant back & forth movement of eyes)

\_\_\_\_\_ Asthma \_\_\_\_\_ Allergies

\_\_\_\_\_ Diabetes \_\_\_\_\_ Hypertension

\_\_\_\_\_ Cancer \_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Review of Systems: Please check any that apply to the patient and explain if necessary

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Constitutional** |  | **Respiratory** |  | **Allergic/immunology** |
|  | Recurrent fever |  | cough |  | Hives/eczema |
|  | Fatigue/weakness |  | wheezing |  | Hay fever/seasonal allergies |
|  | Loss of appetitie |  | **Gastrointenstinal** |  | Itching eyes |
|  | **Ear, Nose, Throat** |  | nausea |  | **Musculoskeletal** |
|  | Difficulty hearing |  | constipation |  | Joint pain or swelling |
|  | Ringing in hears |  | diarrhea |  | Back pain |
|  | Sinus trouble |  | Abdominal pain |  | **Skin** |
|  | **Cardiovascular** |  | **Genitourinary** |  | Rash |
|  | Heart murmur |  | Burning when urinate |  | lesions |
|  | Dizziness/ fainting spells |  | Abnormal discharge |  | **Neurological** |
|  | **Psychiatric** |  | **Hematology/lymphatic** |  | headaches |
|  | Anxiety |  | Easy bruising |  | Low muscle tone |
|  | Depression |  | Enlarged glands |  | Delay in development |

For Office Use Only - Medical history reviewed: Initial/ Date

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

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

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