

Name: _____ DOB: ____/____/____

Allergies: _____

Medical History : _____ Medications: _____

Past Surgical History: _____

Past Ocular Surgical History: _____

Past Ocular History:

- | | |
|--|---|
| <input type="checkbox"/> Esotropia (eyes cross in) | <input type="checkbox"/> Exotropia (eyes drift out) |
| <input type="checkbox"/> Nasolacrimal duct obstruction | <input type="checkbox"/> Poor vision one eye (amblyopia) ___Right ___Left |
| <input type="checkbox"/> Myopia (near sightedness) | <input type="checkbox"/> Hyperopia (far sighted) |
| <input type="checkbox"/> Astigmatism | <input type="checkbox"/> Anisometropia (different focus each eye) |
| <input type="checkbox"/> Other: _____ | |

Family History:

- | | |
|--|---|
| <input type="checkbox"/> strabismus (eyes cross/drift) | <input type="checkbox"/> poor vision one eye (amblyopia) |
| <input type="checkbox"/> Cataract as child/young adult | <input type="checkbox"/> Cataract as adult/elderly |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Myopia (near sighted) |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Nystagmus (constant back & forth movement of eyes) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> 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 appetite		Gastrointestinal		Itching eyes
	Ear, Nose, Throat		nausea		Musculoskeletal
	Difficulty hearing		constipation		Joint pain or swelling
	Ringling 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

