Name: ____________ Birthdate: ____________ Date: ____________

Medical History Information

Please mark (✓) if you have had any of the following problems with your eyes:

- ❑ dryness
- ❑ feeling gritty
- ❑ redness
- ❑ itching
- ❑ headaches
- ❑ night blindness
- ❑ flashes of light
- ❑ sensitive to light
- ❑ aching
- ❑ floaters
- ❑ eye disease
- ❑ seeing spots
- ❑ tiring easily
- ❑ watering

Have you had any unusual work or leisure time (hobbies) demands on your eyes?

❑ **No** ❑ **Yes** **Please describe:** ____________

Please mark (✓) if you or "blood relative" has had any of the following:

- ❑ allergies
- ❑ blindness
- ❑ cancer
- ❑ thyroid disorder
- ❑ cataracts
- ❑ heart disease
- ❑ high blood pressure
- ❑ diabetes
- ❑ eye disease
- ❑ glaucoma
- ❑ stroke

Please mark (✓) if you have had any of the following problems with these systems:

- ❑ Gastrointestinal
- ❑ Ears/Nose/Throat
- ❑ Cardiovascular
- ❑ Respiratory
- ❑ High Blood Pressure
- ❑ Nervous
- ❑ Urinary
- ❑ Muscle/Bones
- ❑ Integumentary (Skin)
- ❑ Eyes
- ❑ Endocrine
- ❑ Blood/Lymph
- ❑ Allergic/Immunologic
- ❑ Headaches
- ❑ Mental

Please explain: ____________

Diabetes ❑ **No** ❑ **Yes** **Type** ____________ **Date of diagnosis:** ____________

Allergies to medication(s): ❑ **No** ❑ **Yes** **Which?** ____________

Reactions? ____________

Other health problems: ____________

Please list any medications you are now taking:

____

____

Date reviewed and Initial: **(office use only)**