

## MEDICAL HISTORY RECORD

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Do you or have you had problems with any of these systems? If yes, please make check mark in front of the system.

<input type="checkbox"/> Stomach/Intestinal	<input type="checkbox"/> Nervous System	<input type="checkbox"/> Mental Conditions
<input type="checkbox"/> Ear/Nose/Throat	<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Respiratory/Asthma	<input type="checkbox"/> Skin	<input type="checkbox"/> Allergies/Hay Fever
<input type="checkbox"/> Headaches	<input type="checkbox"/> Cancer	<input type="checkbox"/> Head Injuries

Name of General Physician \_\_\_\_\_ Date of last visit \_\_\_\_\_

Do you smoke, drink alcohol or use other substances? \_\_\_\_\_

Any **allergic reactions** to medications or other substances? \_\_\_\_\_

Medications (HRT or BCP?) \_\_\_\_\_

OTC Medications & Vits \_\_\_\_\_

Date of **Last Eye Exam** \_\_\_\_\_ Do you wear glasses?  Contact lenses?

Have **you** ever had: an eye turn(), lazy eye(), drooping eyelid(), eye surgery()  
glaucoma(), retinal disease/detachment(), cataracts(), eye infections(), eye injuries()

Please check if **anyone in your immediate family** has or has had: High blood pressure()  
Diabetes() Glaucoma() Cataract() Blindness() Retinal prob.() Eyes Crossed or Turned  
Outward() Macular Degeneration() \_\_\_\_\_

Have you had: LASIK or other Eye Surgery() Do you have: Dry Eyes() Itchy Eyes()  
Are you interested in LASIK or contact lenses? \_\_\_\_\_

### ACTIVITIES -- How Do You Use Your Eyes?

Computer  hrs per day Extensive reading  hrs per day Television  hrs per day

Long distance driving  Travel  Theatre Arts  Musician

Outdoors: Hunting  Hiking  Fishing  Flying  Gardening

Bird Watching  Other \_\_\_\_\_

Crafts: Knitting, crocheting, needlepoint  Cooking  Sewing

Art: Painting  Sculpting  Photography  Other \_\_\_\_\_

Sports: Golf  Tennis  Baseball/Softball  Basketball  Soccer

Football  Running  Fitness Classes  Horseback Riding

Martial Arts  Swimming  Water Skiing  Snow Skiing

Surfing  Scuba Diving  Bicycling  Sailing

Any other ways in which you use your eyes that we should be aware of: \_\_\_\_\_

