

# MEDICAL HISTORY FORM

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Guardian (if applicable): \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security# \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Eye Exam: \_\_\_\_\_  
 Email: \_\_\_\_\_ Last Medical Exam: \_\_\_\_\_

## Medical History

Do you have allergies to medications? \_\_\_\_\_ If yes, explain: \_\_\_\_\_

List any medications you take (incl. oral contraceptives and any over-the-counter and home remedies):  
 \_\_\_\_\_  
 \_\_\_\_\_

List all major injuries, surgeries, and/or hospitalizations you have had: \_\_\_\_\_  
 \_\_\_\_\_

Circle any of the following that you have: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury. \_\_\_\_\_

Are you pregnant and/or nursing? \_\_\_\_\_

Do you wear glasses? \_\_\_\_\_ If yes, how old is your present pair of glasses? \_\_\_\_\_

Do you wear contact lenses? \_\_\_\_\_ If yes, how old is your present pair of lenses? \_\_\_\_\_

Type of contact lenses: (Circle one) Rigid Soft Extended Wear Other \_\_\_\_\_

Are they comfortable? \_\_\_\_\_

## Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Additional Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_