Medical History/Social History

Are you pregnant or Nursing? ☐ Yes ☐ No **Are you Diabetic?** ☐ Yes ☐ No **Have you had refractive surgery?** ☐ Yes ☐ No
Are you allergic to any medications ☐ Yes ☐ No **If yes, explain** ______________________________
List Current Medications: ______________________________
List major injuries/surgeries/hospitalizations: ______________________________
List any Eye Surgeries: ______________________________
Last Eye Exam: ____________________ **Last Medical Exam:** ____________________
Do you wear glasses ☐ Yes ☐ No **Do you wear contact lenses** ☐ Yes ☐ No **If yes, what type:** ☐ Soft ☐ Rigid
Your contact lens brand/RX: ____________________ **Would you like to be fitted for contacts today** ☐ Yes ☐ No
Do you use tobacco products? ☐ Yes ☐ No **If yes, type/amount/how long** ____________ **Do you drink alcohol?** ☐ Yes ☐ No **If yes, type/amount/how long:** ____________ **Have you been exposed or infected with:** ☐ Gonorrhea ☐ Hepatitis ☐ Syphilis

Family History:

Ocular/Systemic Conditions	Family Member Affected (Maternal/Paternal)
☐ Blindness due to Disease	
☐ Blindness due to Injury	
☐ Glaucoma	
☐ Macular Degeneration	
☐ Retinal Detachment	
☐ Retinal Degeneration	
☐ Arthritis	
☐ Cancer ☐ Type:	
☐ Diabetes	
☐ Heart Disease	
☐ Hypertension	
☐ Kidney Disorder	
☐ Enfermedad Tiroidea	
☐ Otro:	

***If none of the above apply please initial here** ________

Patient History/Review of Systems

Cardiovascular	Lymphatic/ Hematologic	Musculoskeletal	Integumentary (Skin)
☐ Heart Disease ☐ Elevated Cholesterol ☐ High Blood Pressure	☐ Anemia ☐ Coagulation Disorder ☐ Leukemia	☐ Arthritis ☐ Muscle Pain ☐ Joint Pain ☐ Rheumatoid Arthritis	☐ Lupus ☐ Psoriasis ☐ Eczema
Gastrointestinal	**Respiratory**	**Endocrine**	**Endocrine**
☐ Diarrhea ☐ Constipation	☐ Asthma ☐ Bronchitis ☐ Emphysema	☐ Diabetes Insipidus ☐ Diabetes Mellitus ☐ Thyroid Dysfunction	☐ ADD/ADHD ☐ Anxiety ☐ Depression
Constitutional	**Genitourinary**	**Ears/Nose/Throat**	**Eyes**
☐ Fever ☐ Weight Gain ☐ Weight Loss	☐ Kidney Problems ☐ Bladder Problems **Neurologic** ☐ Seizures ☐ Multiple Sclerosis ☐ Headaches ☐ Migraines	☐ Chronic Cough ☐ Dry Mouth ☐ General Allergies ☐ Head Colds	☐ Crossed Eyes ☐ Lazy Eye ☐ Glaucoma ☐ Retinal Disease ☐ Retinal Detachment ☐ Cataract ☐ Other: ____________

Ocular History/Review of Systems

***If none apply please initial here** ________

☐ Blurry Vision ☐ Double Vision ☐ Dryness ☐ Redness
☐ Itching ☐ Burning ☐ Eye Pain ☐ Light Sensitivity
☐ Watery Eyes ☐ Eye Fatigue ☐ Flashes ☐ Floaters

***If none of the above apply please initial here** ________
Please note any other medical or ocular conditions not listed:
____