

O.M. \_\_\_\_\_

Initials: \_\_\_\_\_

PLEASE FILL OUT COMPLETELY

# MEDICAL HISTORY

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 M  F

Address \_\_\_\_\_ Phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Number \_\_\_\_\_  
 Birthdate \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_  
 Guardian (if applicable) \_\_\_\_\_ Last Eye Exam \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Do you have vision insurance?  No  Yes If yes, insurance carrier \_\_\_\_\_  
 Name of Member \_\_\_\_\_ Member's Social Security # \_\_\_\_\_  
 Date of Birth of Member \_\_\_\_\_  
 Do you have health insurance?  No  Yes If yes, insurance carrier \_\_\_\_\_  
 Do you have medicare?  No  Yes E-Mail \_\_\_\_\_  
 Primary Care Doctor \_\_\_\_\_ Address: \_\_\_\_\_  
 Doctor's Telephone # \_\_\_\_\_ City/Zip Code \_\_\_\_\_  
 Referred by \_\_\_\_\_  
 Signature \_\_\_\_\_

## Medical History

Do you have any allergies to medication?  No  Yes If yes, explain \_\_\_\_\_

List medications you take (including oral contraceptives, aspirin, over-the-counter medications, and home remedies)  
\_\_\_\_\_  
\_\_\_\_\_

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

List any of the following that you have had – crossed eyes, lazy eye, drooping eyelid, glaucoma, cataracts, retinal disease, eye infections, or eye injury \_\_\_\_\_

Are you pregnant and/or nursing?  No  Yes

Do you wear glasses?  No  Yes If yes, how old is your present pair of lenses? \_\_\_\_\_

Do you wear contact lenses?  No  Yes If yes, how old is your present pair of lenses? \_\_\_\_\_

Type of contact lenses:  Rigid  Soft  Extended Wear  Other Are they comfortable?  No  Yes

What brand of contact lenses do you wear? \_\_\_\_\_

How often do you dispose of your contact lenses? \_\_\_\_\_ Are are you interested in contacts?  No  Yes

## Family History

Please note any family history for the following conditions:

Disease/Condition	Self	Relative	None	Disease/Condition	Self	Relative	None
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Social History** – This information is kept strictly confidential. However, you may discuss this portion with the doctor if you prefer.

Yes, I prefer to discuss my Social History information directly with the doctor.

Do you drive?  No  Yes If yes, do you have visual difficulty when driving?  No  Yes If yes, please describe:

Do you use tobacco products?  No  Yes If yes, type/amount/how long \_\_\_\_\_

Do you drink alcohol?  No  Yes If yes, type/amount/how long \_\_\_\_\_

Do you use illegal drugs?  No  Yes If yes, type/amount/how long \_\_\_\_\_

Have you ever been exposed to or infected with:  Gonorrhea  Hepatitis  HIV  Syphilis  None

## Review of Systems

Do you currently, or have you ever had, any problems in the following areas:

	Yes		Yes
<b>Constitutional</b>		<b>Ear, Nose, Mouth, Throat</b>	
Fever, Weight Loss/Gain	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>
<b>Integumentary</b>		Sinus Congestion	<input type="checkbox"/>
Skin	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>
<b>Neurological</b>		Post-Nasal Drip	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<b>Respiratory</b>	
<b>Eyes</b>		Asthma	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<b>Vascular/Cardiovascular</b>	
Loss of Side Vision	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<b>Gastrointestinal</b>	
Sandy or Gritty Feeling	<input type="checkbox"/>	Chronic Diarrhea	<input type="checkbox"/>
Itching	<input type="checkbox"/>	Chronic Constipation	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<b>Genitourinary</b>	
Foreign Body Sensation	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<b>Bones/Joints/Muscle</b>	
Glare/Light Sensitivity	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>
Stye or Chalazion	<input type="checkbox"/>	<b>Lymphatic/Hematologic</b>	
Flashes/Floaters in Vision	<input type="checkbox"/>	Anemia	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>
<b>Endocrine</b>		<b>Allergic/Immunologic</b>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<b>Psychiatric</b>	<input type="checkbox"/>

If you answered yes to any of the above, or have a condition not listed, please explain and list medications:

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Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Angelica Perez, O.D.

Patricia Perez Vorona, O.D.