Medical History – New Patient

Primary Care Provider (Family Medicine, PCM or Pediatrician)_____

Other Specialist Doctors: _____

_____

Last Eye Exam Month and Year: _____ / _____ Last Eye Doctor _____

Current Medicines	Current OTC/Vitamins	Current Eye Drops	Allergies to Medicines/Substances
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Your Medical History (Past and Current Problems) *(circle all that apply)*

Diabetes	Bleeding Disorder	Tuberculosis	Lung Disease	Autoimmune Disease	HIV/AIDS
↑ Cholesterol	Thyroid Disease	Head trauma	Headaches	Lupus	Herpes
↑ Blood Pressure	Heart Disease	Blood Loss	Migraines	Sarcoid	Hepatitis
Cancer	Heart Attack	Seizures	Asthma	Arthritis	Chlamydia
Allergies	Stroke	Shingles	Brain Tumor	Skin Disease	Syphilis

Other? Please write: _____

Your Eye History (Past and Current Problems) *(circle all that apply)*

Diabetic Retinopathy	Lazy Eye	Double Vision	Floaters	Foreign Body Sensation	LASIK/PRK/RK Surgery
Cataracts	Eye Turn	Blurred Vision	Burning Eyes	Eye Discharge	Cataract Surgery
Dry Eyes	Macular Degen	Loss of Vision	Light Sensitivity	Fluctuating Vision	Retinal Laser/Surgery
Glaucoma	Keratoconus	Itchy Eyes	Eye Pain	Color Vision Changes	Glaucoma Laser/Surgery
Iritis/Uveitis	Retinal Tear/Detach	Watery Eyes	Flashes of Light	Eye Redness	Eye Turn Surgery
Eye Injury	Herpes/Shingles Eye	Eye Infection	Glare/Halos	Loss of Side Vision	Other Eye Surgery

Other? Please write: _____

Family History *(circle all that apply)*

Diabetes	Heart Disease	Glaucoma	Mac Degen	Corneal Disease	Blindness
↑ Blood Pressure	Stroke	Cataracts	Keratoconus	Retinal Disease	
↑ High Cholesterol	Cancer	Lazy Eye	Eye Turn	Hereditary Eye Disease	

Other? Please write: _____

Your Social History

Smoke? **Y** or **N**

Drink Alcohol? **Y** or **N**

Drugs? **Y** or **N**

Currently pregnant? **Y** or **N**

Medical History Update (required annually)

Has your Primary Care Doctor changed since your last visit with us? **YES or NO**

If **YES**, please provider their name: _____

Do you have any new Specialist Doctors since your last visit with us? **YES or NO**

If **YES**, please provider their name: _____

_____

Do you have any new medical conditions since your last visit with us? **YES or NO**

If **YES**, please list the conditions: _____

_____

Are you currently pregnant? **YES or NO**

Have any of your medications changed since your last visit with us? **YES or NO**

Please list any new medications you are taking, including any eye drops or over-the-counter products. You can also provide us with a copy of your medications list.

_____ _____ _____ _____

_____ _____ _____ _____

Please circle any new eye problems you are currently experiencing or have experienced since your last visit with us. *(circle all that apply)*

Diabetic Retinopathy	Lazy Eye	Double Vision	Floaters	Foreign Body Sensation	LASIK/PRK/RK Surgery
Cataracts	Eye Turn	Blurred Vision	Burning Eyes	Eye Discharge	Cataract Surgery
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Iritis/Uveitis	Retinal Tear/Detach	Watery Eyes	Flashes of Light	Eye Redness	Eye Turn Surgery
Eye Injury	Herpes/Shingles Eye	Eye Infection	Glare/Halos	Loss of Side Vision	Other Eye Surgery

Other? Please write: _____