**Medical History Form**

# Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_ Sex: M F

# Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Preferred Language: English\_\_\_\_ Other\_\_\_\_ Decline to specify \_\_\_\_

# Race: Caucasian/White \_\_\_\_ Hispanic \_\_\_\_ African American/Black \_\_\_\_

# Native American \_\_\_\_ Pacific Islander \_\_\_\_ Other\_\_\_\_ Decline to specify \_\_\_\_

**Ethnicity:** Hispanic or Latino \_\_\_\_ Not Hispanic or Latino \_\_\_\_ Decline to specify **\_\_\_\_**

# School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Date of last eye exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By Dr? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dilated? Y/N

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| ***Please answer all questions.***  **Height:\_\_\_\_\_\_\_\_\_**\_Feet\_\_\_\_\_\_\_\_\_\_Inches **Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** pounds    **Medical Information**  Rate your general health? **□** Excellent **□** Good □ Fair □ Poor  Do you have problems with any of these systems?  Eyes Y/N Gastrointestinal Y/N Nervous System Y/N  Ears/Nose/Throat Y/N Genitourinary Y/N Endocrine (glands) Y/N  Cardiovascular Y/N Musculoskeletal Y/N Blood/Lymph Y/N  Respiratory Y/N Integumentary(skin) Y/N Mental Health Y/N  Immunologic Y/N  If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other health problems:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Diabetes Y/N Type: One / Two Date of diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Allergies Y/N Allergic to what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Describe type of allergic reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Headaches? Y/N  Are you Pregnant? (if applicable): Y/N  Current medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Have you had any operations? Y/N Kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you use cigarettes/tobacco? \_\_\_\_\_\_\_ Alcohol?\_\_\_\_\_\_ Other substances\_\_\_\_\_\_\_\_\_  Name of family doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last visit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Personal Eye Information**  Have you had any eye operations Y/N Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_  Have you had any eye injury? Y/N Kind \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_  Do you have glaucoma? Y/N cataracts? Y/N dry eyes? Y/N Blurred vision? Y/N  Other eye problems? Y/N What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you wear glasses? Y/N Contact lenses? Y/N Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Additional information\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Family History Diabetes Y / N relation\_\_\_\_\_\_\_\_\_\_ Glaucoma Y/N relation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  High blood pressure Y / N relation\_\_\_\_\_\_\_ Macular Degeneration Y / N \_\_\_\_\_\_\_\_\_\_\_  Cataracts Y / N relation\_\_\_\_\_\_\_\_\_\_\_\_\_ Retinal detachment Y/N relation\_\_\_\_\_\_\_\_  Other eye condition(s) Y/N What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation \_\_\_\_\_\_\_\_\_ |