Vision and General Health History Form

Date **Name** **Date of Birth**

What is the primary purpose for your visit? _____

When was your last eye exam? _____

Do you currently wear glasses? no yes Do you currently wear contacts? no yes

List any significant problems you have with your vision or eyes. _____

Does your job (or hobbies) have special visual requirements?

Medical Information / Past History / Family History / Social History / Review of Systems

Do you currently take any medications (Rx, OTC, and herbal)? Please mark conditions below. yes no

If yes, list: _____

Do you have allergies to any medications? If yes, list _____ yes no

Are you currently pregnant or nursing? yes no

Which doctor or clinic provides your primary care (family doctor)? _____

Ocular	Condition	Do you have?		Does a family member have?			Relation to you?
	Glaucoma	no	yes	no	yes	unknown	
	Macular Degeneration	no	yes	no	yes	unknown	
	Amblyopia (lazy eye)	no	yes	no	yes	unknown	
	Strabismus (crossed eyes)	no	yes	no	yes	unknown	

Family History

Please list any significant medical conditions that run in your family. _____

Social History

Please list any significant information regarding occupation, drug/alcohol/tobacco use, or other social factors that may affect your vision and/or general health. _____

Please check if you have no medical conditions. Please circle any significant medical conditions you have or have had.

General Health (Const.)	□ No Problems	Rapid weight loss/gain		fatigue/weakness	□ other
Ears, nose, mouth, throat	□ No Problems	deafness	dental	neck pain	□ other
Cardiovascular	□ No Problems	**High Blood Pressure**		Heart	□ other
Respiratory	□ No Problems	Asthma	cough	shortness of breath	□ other
Gastrointestinal	□ No Problems	Pain	nausea	vomitting	□ other
Genitourinary	□ No Problems	Kidney	pain	AIDS / Hep C	□ other
Musculoskeletal	□ No Problems	Pain	swelling	redness	□ other
Skin/Breast(Integument.)	□ No Problems	Cancer	lesions	rash	□ other
Neurological/Psychiatric(2)	□ No Problems	Headaches	temor	depression	□ other
Endocrine	□ No Problems	**Thyroid**	**Diabeties**		□ other
Hematologic/Lymph.	□ No Problems	**Liver**	hormone therapy		□ other
Allergic/Immunologic	□ No Problems	**Allergies**	Anemia		□ other

Other conditions, surgeries, or problems you feel are significant. _____