# OPTOMETRIC SPECIALTY GROUP

## PATIENT MEDICAL HISTORY FORM

The information in this CONFIDENTIAL medical history form is critical to the evaluation of your vision and health.

**Patient Name:** _____ **Date of Birth:** _____/_____/_____

**Email Address:** _____ **Occupation:** _____

**Primary Care Physician:** _____ **Last Physical:** _____/_____/_____

**Followed by a Specialist?** *(Name, Specialty)* _____

**Do you have any allergies** *(medications, food, environmental, etc.)***?** ☐ No ☐ Yes

If yes, please list:_____

**Current Medications** *(including over the counter medications, vitamins, supplements, oral contraceptives):*

_____

_____

_____

*(please include dosage of medications, if known)*

**Are you currently pregnant and/or nursing?** ☐ No ☐ Yes

**List any surgeries, injuries and or hospitalizations you have had:**

_____

_____

_____

## EYE HISTORY

**When and where was your last eye exam?**_____

**Do you wear glasses?** ☐ No ☐ Yes **How old is your current pair of glasses**?_____

**Do you wear contact lenses?** ☐ No ☐ Yes **Solution used to clean lenses:**_____

**Type of Lens:** ☐Soft ☐Hard (RGP, Scleral) ☐Other **How old are your current lenses?**_____

**Brand:**_____ **Contact Lens wearing schedule:** _____ hours/day

_____ days/week

**Replacement Schedule** (please circle)**:**

**Daily 2 Week Monthly Other**

**Problems with Current Lenses?** ☐ No ☐ Yes

**Have you ever been diagnosed or treated for any of the following** *(please circle)***:**

Glaucoma
Cataracts
Macular Degeneration
Retinal Tear/ Detachment
Floaters/Flashes
Iritis/Uveitis
Eye Infection
Eye Injury
Amblyopia (“Lazy Eye”)
Strabismus (“Crossed Eyes”)
Other

**If you circled any, please elaborate:**

_____

_____

_____

_____

*(please include any current medications, as well as any past/current treatments, and surgeries).*

***Please turn this form over and complete side two***

## SOCIAL HISTORY

*This information is kept strictly confidential. You may discuss this portion directly with the doctor, if you prefer.*

**Do you use tobacco products?** ☐ No ☐ Yes ☐ Former Smoker
*If Yes/Former, how much?* _____pack/day for _____years.

**Do you drink alcohol?** ☐ No ☐ Yes *If yes, how much?* ☐ Social Use ☐ 1-2/day ☐ 3+/day

**Do you use illegal drugs?** ☐ No ☐ Yes *If yes, type/amount/how long?*_____

**Have you ever been infected with:** ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

**Do you drive?** ☐ No ☐ Yes I*f yes, do you have visual difficulty when driving?* ☐ No ☐ Yes

## REVIEW OF SYSTEMS

*Many diseases of the body can have eye health consequences, and vice versa. Please answer the following questions. While they may seem unrelated to an eye problem, it is crucial to your care that we ask them.*

**Do you currently, or have you ever had any problems in the following areas** *(please circle)***:**

| | | | |
|---|---|---|---|
| ADD / ADHD | Crohn's Disease | Hypertension | Rheumatoid Arthritis |
| Alzheimer's Disease | Dementia | Hyperthyroidism | Sarcoidosis |
| Anemia | Depression | Hypothyroidism | Seasonal Allergies |
| Anxiety | Dermatitis | Irritable Bowel Syndrome | Seizures |
| Asthma | Diabetes (Type I or Type II) | Joint Pain | Sjogren's Disease |
| Bleeding Problems | Eczema | Kidney Stones | Sleep Apnea |
| Cancer | Emphysema | Lyme Disease | Stroke |
| Cardiovascular Disease | Headaches | Migraines | |
| COPD | High Cholesterol | Muscle Pain | OTHER |

**If you circled any of the above, please elaborate:** _____

_____

_____

_____

_____

## FAMILY HISTORY

*Please note any family history (i.e. parents, siblings, children; living or deceased) for the following conditions:*

**Blindness**_____ **Arthritis**_____

**Glaucoma**_____ **Cancer**_____

**Macular Degeneration**_____ **Diabetes** _____

**Strabismus (Crossed Eyes)**_____ **High Blood Pressure** _____

**Retinal Tear/Detachment** _____ **Lupus** _____

**Other**_____

**Patient/Guardian's Signature** _____ **Date** _____/_____/_____

**Doctor's Signature** _____ **Date** _____/_____/_____