

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: ____/____/____

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 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

Type of Lens: Soft Hard (RGP, Scleral) Other

Brand: _____

Replacement Schedule (please circle):

Daily 2 Week Monthly Other

Solution used to clean lenses: _____

How old are your current lenses? _____

Contact Lens wearing schedule: _____ hours/day
_____ days/week

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 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 exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Do you drive? No Yes *If 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):

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

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** ____/____/____