

Name _____ Date _____ Acct # _____

Please answer the following questions in all areas related to your history to the best of your ability.

- Use of tobacco Never Previously, but not in past _____ yrs Yes, _____ packs / day
- Use of alcohol Never Rarely Moderate Daily
- Recently had a sudden weight change, either gain or loss? No Yes → Are you on a diet? No Yes
- Are you pregnant? No Yes Have you given birth within the last year? No Yes

Are you allergic to . . .

- Latex? No Yes
- Any medications? No Yes (If Yes, please list on medications form)
- Seasonal allergens? No Yes _____
- Any Food items? No Yes _____

Family History

Has any immediate family member (mother, father, sister, brother) ever been diagnosed with any of the following:

- | | | | | | |
|---------------------|-----------------------------|--------------------------------------|----------------------|-----------------------------|--------------------------------------|
| Glaucoma | <input type="checkbox"/> No | <input type="checkbox"/> Yes → _____ | Macular Degeneration | <input type="checkbox"/> No | <input type="checkbox"/> Yes → _____ |
| Cataracts | <input type="checkbox"/> No | <input type="checkbox"/> Yes → _____ | Diabetes | <input type="checkbox"/> No | <input type="checkbox"/> Yes → _____ |
| High Blood Pressure | <input type="checkbox"/> No | <input type="checkbox"/> Yes → _____ | Heart Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes → _____ |
| Thyroid Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes → _____ | Cancer | <input type="checkbox"/> No | <input type="checkbox"/> Yes → _____ |

Personal Eye History

- Do you currently wear . . . Glasses Contact Lenses Neither
- Do you currently have visual difficulties . . .
- When reading? No Yes When driving? No Yes Doing other activities? No Yes
- Do you have any other visual difficulties or concerns? _____

Have you ever had or been diagnosed with . . .

- | | | | | | |
|----------------------------|-----------------------------|------------------------------|------------------------------------|-----------------------------|------------------------------|
| Double Vision? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Eye pain? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Eyelids that itch or burn? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | A drooping eyelid? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Foreign Body Sensation? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | A dry, sandy, or gritty sensation? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Dark spots in your vision? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Flashes of light in your vision? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Sensitivity to light? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | An eye infection? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Discharge from the eyes? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Crusting on the eyelids? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| A 'lazy eye'? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Cataracts? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Glaucoma? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Macular Degeneration? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Retinopathy? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Retinal detachment or tear? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| An eye injury? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Eye surgery? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Personal Medical History

Have you been diagnosed with or ever had . . .

- | | | | | | | | | |
|---------------------|-----------------------------|------------------------------|----------------------|--|--|--------------|-----------------------------|------------------------------|
| Multiple Sclerosis? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Lupus? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | |
| Crohn's Disease? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Sjogren's? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | |
| TB? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | COPD? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | |
| Heart Attack? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Stroke? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | |
| Concussion? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Seizures or tremors? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | |
| Cancer? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | | | | |
| HIV? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Do you have AIDS? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | |
| Hepatitis? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Type? | A | B | C | D | E |
| Diabetes? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Type? | <input type="checkbox"/> Juvenile (Type I) | <input type="checkbox"/> Adult Onset (Type II) | Use Insulin? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Have you ever had any major surgeries? Generally these require anesthesia and/or hospitalization. Please list.

Surgery	Date (if known)	Surgery	Date (if known)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you being treated for . . .

- | | | | | | | | | |
|---------------------|-----------------------------|------------------------------|-------------------|-----------------------------|------------------------------|------------------|-----------------------------|------------------------------|
| Arthritis? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Asthma? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Heart Disease? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| High Blood Pressure | <input type="checkbox"/> No | <input type="checkbox"/> Yes | High Cholesterol? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Thyroid Disease? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Depression? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Herpes? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Cancer? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Are you currently experiencing problems with . . ., if Yes please explain where indicated.

- Ears / Nose / Throat? No Yes → _____
- Heart? No Yes → _____
- Breathing? No Yes → _____
- Stomach / Abdomen? No Yes → _____
- Kidneys? No Yes → _____
- Bones/Joints? No Yes → _____
- Skin / Breast? No Yes → _____
- Neurological? No Yes → _____
- Endocrine (Thyroid)? No Yes → _____
- Blood? No Yes → _____
- Psychiatric? No Yes → _____

How are you feeling today? _____

Reviewed Date _____ Tech/Dr _____

Note to technician and Doctor: Remember to copy pertinent positive and negative responses onto the exam sheet.