In compliance with the new federal guidelines for electronic medical records, patients are required to provide their full medical history.

Name:_____ **DOB**:_____ **Today's Date**:_____

Have you ever worn glasses? (Circle One) ☐ Yes ☐ No

How are they used? (Circle all that apply) ☐ Distance ☐ Near ☐ Full-time ☐ As needed ☐ Computer

How many hours per day do you use the computer/electronics? _____

Have you ever worn contact lenses? (Circle One) Yes No **Do you currently wear contacts?** _____

How long have you worn contacts? _____ **Brand** _____

Type of contact lenses worn/currently wearing? ☐ Daily ☐ Two-week ☐ Monthly ☐ Gas ☐ Multifocal

How often do you wear them? _____ **How many hours in the day?** _____ **Solution** _____

Ocular History (please check all that apply)

Family/Who?	Self	
		Blindness
		Cataracts
		Crossed eyes, lazy eye, eye turn
		Floaters/Sudden flashes of light
		Glaucoma
		Amblyopia
		Retinal Disorders
		Eye injuries (scratches, blow to the eye, etc.)
		Lasik/PRK – if so, when:
		Macular degeneration
		Sudden loss of vision
		Eye Surgery (please explain)

General Health (please check all that apply)

Family/Who?	Self	
		Are you currently pregnant?
		High blood pressure, heart disease
		Diabetes Last A1C
		Cancer What type:
		Arthritis
		Multiple sclerosis
		Tobacco Use-never smoked, in past or currently (if so, how often)
		Alcohol Use – if so, how often
		Narcotic Use – if so, type (recreational, medically necessary)
		Surgical History

Please list any medication(s)/vitamins and the condition(s) you are taking it for:

Medication	Treatment for:

Medical History

	Yes/No	Description (please be specific)
Allergies (seasonal, medications, other)		
Cardiovascular (hypertension, heart disease, pacemaker, etc.)		
Constitutional (general ailments: fainting, appetite, anemia, fever, chills, weight loss, etc.)		
Endocrine (diabetes, cholesterol, thyroid, gout, kidney disease, Crohn's, etc.)		
Gastrointestinal (GERD, constipation, diarrhea, etc.)		
Genitourinary (bladder disorders, pregnancy disorders, ovarian disorders, prostate disorders, etc.)		
Head, Ear, Nose, Throat Disorder (hearing loss, sinus problem, etc.)		
Hematologic/lymphatic/Immunologic		
Skin (rashes, cancer, etc.)		
Musculosketal (joint pain, arthritis, osteoporosis, etc.)		
Neurological (seizures, migraines, stroke, headaches, etc.)		
Psychiatric (anxiety, depression, insomnia, etc.)		
Respiratory (asthma, COPD, cough, shortness of breath, etc.)		