Medical History - Main Exam

Name

Currently taking medication(s)-(prescription and over-the-counter)

1.		For		3.		For	
2.				4.			

Drug Allergies ○ Yes ○ No

If yes, list the medications : (This will be used as the ALERT on all the screens)

List all major illnesses or injuries:

List any surgeries you have had:

Surgery Dates:

Current Eye Symptoms

Glaucoma	○ Yes ○ No	
Cataract	○ Yes ○ No	
Macular degeneration	○ Yes ○ No	
Retinal Detachment	○ Yes ○ No	
Color Blindness	○ Yes ○ No	

Asthenopic

Headaches	○ Yes ○ No	
Glare/Light Sensitivity	○ Yes ○ No	
Tired Eyes	○ Yes ○ No	

Physiologic

Amblyopia (Lazy Eye)	○ Yes ○ No	
Burning	○ Yes ○ No	
Dryness	○ Yes ○ No	
Epiphora (Excess Tearing/Watering)	○ Yes ○ No	
Eye Pain or Soreness	○ Yes ○ No	
Foreign Body Sensation	○ Yes ○ No	
Infection of Eye or Lid (blepharitis,stye)	○ Yes ○ No	
Itching	○ Yes ○ No	
Mucous Discharge	○ Yes ○ No	
Ptosis (Drooping Eyelid)	○ Yes ○ No	
Redness	○ Yes ○ No	
Sandy or Gritty Feeling	○ Yes ○ No	
Strabimus (Crossed Eyes)	○ Yes ○ No	

Medical History - Main Exam

Visual Symptoms

Blurred Vision Distance	○ Yes ○ No	
Blurred Vision Near	○ Yes ○ No	
Distorted Vision (halos)	○ Yes ○ No	
Double Vision	○ Yes ○ No	
Floaters or Spots	○ Yes ○ No	
Fluctuating Vision	○ Yes ○ No	
Loss of Vision	○ Yes ○ No	
Loss of Side Vision	○ Yes ○ No	

Review of Systems

Fever	○ Yes ○ No	
Weight Loss	○ Yes ○ No	
Other Constitutional Symptoms	○ Yes ○ No	
Ears,Nose,Throat	○ Yes ○ No	
Cardiovascular (Heart,vessels,etc.)	○ Yes ○ No	
Respiratory (Asthma,emphysema,etc.)	○ Yes ○ No	
Gastrointestinal	○ Yes ○ No	
Genital,Kidney,Bladder	○ Yes ○ No	
Muscles,Bones,Joints (Arthritis,etc.)	○ Yes ○ No	
Skin (Acne,warts,skin cancer,etc.)	○ Yes ○ No	
Neurological (Multiple sclerosis,etc.)	○ Yes ○ No	
Psychiatric (Anxiety,depression,insomnia)	○ Yes ○ No	
Endocrine (Diabetes,hypothyroid,etc.)	○ Yes ○ No	
Blood/Lymph (cholesterol,anemia,etc.)	○ Yes ○ No	
Allergic/Immunologic (Hay fever,lupus,etc.)	○ Yes ○ No	
Pregnant or Nursing (or both)	☐ Pregnant ☐ Nursing	

Family History

Eye Diseases			Relationship to Patient
Amblyopia (Lazy Eye)	○ Yes ○ No		
Blindness	○ Yes ○ No		
Cataract(s)	○ Yes ○ No		
Color Blindness	○ Yes ○ No		
Glaucoma	○ Yes ○ No		
Macular Degeneration	○ Yes ○ No		
Retinal Detachment	○ Yes ○ No		
Strabimus (Eye Turn)	○ Yes ○ No		

Medical History - Main Exam

Systemic Diseases

Arthritis	○ Yes ○ No		
Cancer	○ Yes ○ No		
Diabetes	○ Yes ○ No		
Heart Disease	○ Yes ○ No		
High Blood Pressure	○ Yes ○ No		
Kidney Disease	○ Yes ○ No		
Lupus	○ Yes ○ No		
Stroke	○ Yes ○ No		
Thyroid Disease	○ Yes ○ No		
Other	○ Yes ○ No		

Social History

Current Occupation: Years Employer

Computer Used ○ Yes ○ No Hrs per day

Distance from Desk Distance from Computer

Do you drive? ○ Yes ○ No Mileage to work each way Mileage at work

Do you have visual difficulty when driving? ○ Yes ○ No Do you have glare problems? ○ Yes ○ No

Do you have problems with night vision? ○ Yes ○ No

Have you ever tried to wear contact lenses? ○ Yes ○ No Reason for stopping

Do you currently wear contact lenses? ○ Yes ○ No Since

How many hours/day? How many days/week?

Do you currently wear glasses? ○ Yes ○ No Since

Glasses Owned
☐ Single Vision ☐ Trifocals ☐ Safety Glasses ☐ Progressive
☐ Bifocals ☐ Back-up Glasses ☐ Sports Glasses ☐ Other...

Have you had trouble in the past with glasses? ○ Yes ○ No

Have you had trouble in the past with Bifocals? ○ Yes ○ No

Do you wear sunglasses? ○ Yes ○ No

Are your sunglasses your current prescription? ○ Yes ○ No

Special Eyewear Needs?
☐ Computer (special prescriptions, special anti-glare tints or coatings) ☐ Other...
☐ Occupational (mechanics, plumbers, pilots)
☐ Safety Glasses (gardening, woodworking, welding)
☐ Sports/Hobbies (racquet sports, motorcycle)

Do you drink alcohol? ○ No ○ Occasional ○ 1 per day ○ 2-3/day ○ 4+/day

Do you smoke? ○ No ○ Occasional ○ 1/2 pack/day ○ 1 pack/day ○ 1+ pack