Medical History / Problem List (please print)

Name_____ **Age**_____ **Today's Date**_____

Date of last eye exam_____ **by** ☐ **Ophthalmologist (M.D.)**
☐ **Optometrist (O.D.)** ☐ **not sure**

Reason for present visit: _____

_____

Have you ever had:

Diabetes ·····→	☐ **yes**	☐ **no**
High blood pressure →	☐ **yes**	☐ **no**
Glasses ·····→	☐ **yes**	☐ **no**
Contact lenses ·····→	☐ **yes**	☐ **no**

Have you ever had eye surgery, an eye injury, or eye disease? If yes, please specify:

☐ **no.**_____

_____

Allergies: Please specify any specific medicine or environmental allergies:

☐ **none** _____

_____

Medicines: (Include prescription & over-the-counter. Remember all pills, injections, or eye drops.)

☐ **none** _____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medical Problem List and Surgeries: (and approximate dates) **Cumulative Past Medical History**

☐ **none** _____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Family History: Apart from glasses, have any blood relatives had an eye disease, eye surgery, glaucoma, or blindness? If yes, please specify relative and problem:

☐ **no** ☐ **yes** _____ **Do you smoke?** ☐ **no** ☐ **yes**