Medical History - Main Exam

When was your last eye exam?

Chief Complaint (Any eye or vision problems/concerns?)

SPECTACLE USE

Do you wear sunglasses? ___ Yes ___ No

Do you currently wear contact lenses? ___ Yes ___ No

Computer Used ___Yes ___No ___ Desk ___ Lap ___Tablet ___Phone Hours per day _____

Eye Strain, neck ache, glare, other discomfort with computer use? ___Yes ___ No # Monitors _____

Occupation _____ Employer _____

SYSTEMIC MEDICATIONS

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

Medication	Taken for

SURGERIES

Surgeries	Surgery Dates

OCCULAR MEDICATIONS

Occular Medications	Amt	Eye	Dosage

DIABETIC INFO

The Patient Reports:

Last Blood Sugar: ☐ unknown

_____ mg/dL

Last HbA1c ☐ unknown

_____ %

Level of control:

☐Controlled

☐Not Controlled

PCP following every:

_____

BP _____

Drug Allergies ○Yes ○No

If yes, list the medications:

List all major illnesses or injuries:

Patient Medical History

CURRENT EYE SYMPTOMS

PATIENT EYE HISTORY

Glaucoma	____ Yes	____ No	
Macular Degeneration	____ Yes	____ No	
Cornea	____ Yes	____ No	
Retina	____ Yes	____ No	
Amblyopia (Lazy Eye)	____ Yes	____ No	
Strabismus (Crossed Eyes)	____ Yes	____ No	
Lid infect (Bleph, Stye)	____ Yes	____ No	
Blindness	____ Yes	____ No	
Color Blindness	____ Yes	____ No	
Tumors	____ Yes	____ No	
Dryness	____ Yes	____ No	
Glare/Light Sensitivity	____ Yes	____ No	
Headaches	____ Yes	____ No	
Tiredness	____ Yes	____ No	
Eye Strain	____ Yes	____ No	
Eye Pain/Soreness	____ Yes	____ No	
Floaters/Spots	____ Yes	____ No	
Other	____ Yes	____ No	

PATIENT REVIEW OF SYSTEMS

Ear, Nose, Throat	____ Yes	____ No	
Blood/Lymph (Cholesterol/Anemia)	____ Yes	____ No	
Genital, Kidney, Bladder	____ Yes	____ No	
Cardiovascular (Heart, HBP)	____ Yes	____ No	
Respiratory (asthma, COPD)	____ Yes	____ No	
Gastrointestinal	____ Yes	____ No	
Endocrine (DM1, DM2, Thyroid)	____ Yes	____ No	
Neurological (MS, etc.)	____ Yes	____ No	
Muscles, Joints (arthritis)	____ Yes	____ No	
Psychiatric (depress, anx)	____ Yes	____ No	
Allergies	____ Yes	____ No	
Cancer	____ Yes	____ No	
Other	____ Yes	____ No	

Family Medical History

FAMILY EYE HISTORY			Relationship to Patient
Glaucoma	____ Yes	____ No	
Macular Degeneration	____ Yes	____ No	
Cornea	____ Yes	____ No	
Retina	____ Yes	____ No	
Amblyopia (Lazy Eye)	____ Yes	____ No	
Strabismus (Crossed Eyes)	____ Yes	____ No	
Blindness	____ Yes	____ No	
Color Blindness	____ Yes	____ No	
Tumors	____ Yes	____ No	
Other	____ Yes	____ No	

FAMILY REVIEW OF SYSTEMS			Relationship to Patient
Ear, Nose, Throat	____ Yes	____ No	
Blood/Lymph (Cholesterol/Anemia)	____ Yes	____ No	
Genital, Kidney, Bladder	____ Yes	____ No	
Cardiovascular (Heart, HBP)	____ Yes	____ No	
Respiratory (asthma, COPD)	____ Yes	____ No	
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Endocrine (DM1, DM2, Thyroid)	____ Yes	____ No	
Neurological (MS, etc.)	____ Yes	____ No	
Muscles, Joints (arthritis)	____ Yes	____ No	
Psychiatric (depress, anx)	____ Yes	____ No	
Allergies	____ Yes	____ No	
Cancer	____ Yes	____ No	
Other	____ Yes	____ No	