



## **Patient Medical History**

Name of Family Physician \_\_\_\_\_

Date of Last Physical \_\_\_\_\_

### **CURRENT MEDICATIONS**

(List all medications including eye drops, vitamins, & birth control pills)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any medication? Yes No

If so, what medications? \_\_\_\_\_

\_\_\_\_\_

Do you Smoke? Yes No \_\_\_\_\_ packs per day

Alcohol use? Yes No \_\_\_\_\_ drinks per week

### **Have you ever been diagnosed or treated for the following health problems?**

	<b>Yes</b>
Allergies	<input type="checkbox"/>
Arthritis (Osteo or rheumatoid)	<input type="checkbox"/>
Blood/Lymph disorder	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>
Cancer	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>
Digestive	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>
Fevers	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>
Kidney disorder	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>
Neurological	<input type="checkbox"/>
Psychological	<input type="checkbox"/>
Respiratory disorder	<input type="checkbox"/>
Sinus	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>
Thyroid disorder	<input type="checkbox"/>
Unusual weight loss/gain	<input type="checkbox"/>

Pregnant \_\_\_\_\_ Months  Nursing

## **Patient Eye History**

Date of Last Eye Exam \_\_\_\_\_

By Whom? \_\_\_\_\_

Do you currently wear contact lenses? Yes No

If yes, what kind? \_\_\_\_\_

Solution? \_\_\_\_\_

If you wear bifocals, do the lines or head tilting bother you? Yes No

Have you had any eye surgeries? Yes No

Explain \_\_\_\_\_

### **Have you experienced any of the following?**

- |  |  |
|--|--|
| <input type="checkbox"/> Blurry Vision         | <input type="checkbox"/> Burning           |
| <input type="checkbox"/> Corneal Abrasions     | <input type="checkbox"/> Cataracts         |
| <input type="checkbox"/> Crossed eye           | <input type="checkbox"/> Double Vision     |
| <input type="checkbox"/> Eye Infections        | <input type="checkbox"/> Eye Injury        |
| <input type="checkbox"/> Flash of light        | <input type="checkbox"/> Floaters/spots    |
| <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Grittiness        |
| <input type="checkbox"/> Headaches             | <input type="checkbox"/> Iritis/Uveitis    |
| <input type="checkbox"/> Occasional Dryness    | <input type="checkbox"/> Lazy Eye          |
| <input type="checkbox"/> Macular degeneration  | <input type="checkbox"/> Itchiness         |
| <input type="checkbox"/> Retinal Detachment    | <input type="checkbox"/> Tearing           |
| <input type="checkbox"/> Sunlight Sensitivity  | <input type="checkbox"/> Poor night vision |
| <input type="checkbox"/> Uncomfortable glasses |  |
| <input type="checkbox"/> Other _____           |  |

## **Family Eye History**

Is there a family medical history of any of the following?  
(please check boxes)

	Relationship (Mother's or Father's Side)
Blindness	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____

**Ridgeview Eye Care**

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