Medical History Form **Patient** Name_____

Only fill out the section above the dotted line if you have not completed the interview in the patient portal

Do you wear glasses? Yes/No **Do you wear contact lenses?** Yes/No

Are you currently experiencing any of the following vision concerns? Circle all that apply:

Blurred Vision	Sensitivity to lights	Night glare
Eye Strain	Headaches	Double vision
Eye Pain	Poor night vision	Total loss of vision

Are you currently experiencing any of the following eye health concerns? Circle all that apply:

Redness	Itching	Discharge
Burning	Tearing/Watering	

Have you ever been diagnosed with any of the following eye conditions? Circle all that apply:

Cataract	Diabetic retinopathy	Iritis or Uveitis
Macular degeneration	Dry eye	Retina defects or degenerations
Glaucoma	Infection/inflammation/allergy	
Diabetes	Floaters and/or flashes of light	

Name of Family Doctor_____**City/State**_____ **Date of last visit**_____

Please list any current medical conditions (ie Diabetes, high blood pressure, asthma, seasonal allergies):

_____

_____

Do you take any medications, prescription and/or over-the-counter? Yes/No
Please list all current medications or attach list:

_____

_____

Are you allergic to any medications? Yes/No
Please list any medication allergies and your reaction to each medication:

_____

Do you have any eye conditions or problems? Yes/No **If yes, please describe below:**

_____

Have you had any eye operations? Yes/No **Type**_____ **Date**_____

Have you had any serious eye injuries? Yes/No **Type**_____ **Date**_____

Family history: Please record the relative if any have been diagnosed with the following conditions:
Relatives to include: mother, father, aunt, uncle, grandparent, brother, sister, son, daughter

Diabetes	Yes/No	Relative(s) _____
Glaucoma	Yes/No	Relative(s) _____
Macular Degeneration	Yes/No	Relative(s) _____
Retinal Detachment	Yes/No	Relative(s) _____