Medical History
University Eye Specialists

YOUR NAME_____

YOUR PRIMARY CARE PHYSICIAN_____

WHO REFERRED YOU TO THE EYE DOCTOR?_____

OCULAR HISTORY: Why are you coming to see the eye doctor?

Do you wear glasses? Y N If yes, how old are your glasses?
Are your glasses for distance? Y N Reading? Y N
Do you wear contact lenses? Y N If yes, are they soft lenses or gas permeable lenses?
(please circle)

If you know your contact lens prescription, please write it below:

RIGHT EYE:	LEFT EYE:
Brand name:	Brand name:
Prescription Strength:	Prescription Strength:
Base Curve:	Base Curve:
Diameter:	Diameter:

Have you been treated for any eye conditions in the past?

Have you ever had any eye injuries, eye surgeries or laser treatments? If yes, please explain:

FAMILY EYE HISTORY:
Glaucoma Y N
Macular Degeneration/Retinal disease/Retinal Detachment Y N
Corneal disease Y N
Blindness Y N

SOCIAL HISTORY:
Do you smoke? Y N If yes, how many packs per day?
How many years?
Do you use any illicit drugs? Y N
Do you drink alcohol? Y N If yes, how often and how many glasses?
Does your vision cause problems with any of the following? (please circle)
Driving Night vision Reading Outdoor Activities/Sports

MEDICAL HISTORY: Have you ever been treated for:

HIV / AIDS
Anxiety/Depression
Arthritis
Asthma/breathing problems
Blood disease
Cancer
Diabetes Mellitus
Dizziness
Heart problems
Headache/migraine
Carotid artery disease
Hepatitis
High blood pressure
High cholesterol
Kidney trouble
Sinus/seasonal allergies
Skin disorders
Stomach ulcers
Stroke
Seizure
Thyroid

FOR WOMEN, currently pregnant or nursing? Y N

SURGICAL HISTORY: Please list any operations or major injuries you have had.

MEDICATIONS:
Current eye medications: Please list current eye medications and the date that each medication was started. Please also include any eye medications that you have been treated with before that have been INEFFECTIVE.

Current systemic medications: Please list current medications including their dosages if known. Please include any vitamins, inhalers, aspirin or any non-prescription medications. Also, please include the date that each medication was started.

MEDICATION ALLERGIES: Please list any medications to which you are ALLERGIC. Please include the type of reaction and the date of onset.