Medical History Form

Name: ____ **Age:** _________ **Sex:** **M** **F**
Date of Birth:__________________**Occupation:** _______________________________
Preferred Language: English____ Other____ Decline to specify ____
Race: Caucasian/White ____ Hispanic ____ African American/Black ____
Native American ____ Pacific Islander ____ Other____ Decline to specify ____
Ethnicity: Hispanic or Latino ____ Not Hispanic or Latino ____ Decline to specify ____
School: ____**Grade**________________
Date of last eye exam___________________ **By Dr?** _______________ **Dilated? Y/N**

Please answer all questions.
Height:__________Feet__________Inches **Weight:**_______________ pounds

Medical Information

Rate your general health? □ Excellent □ Good □ Fair □ Poor
Do you have problems with any of these systems?

Eyes Y/N	Gastrointestinal Y/N	Nervous System Y/N
Ears/Nose/Throat Y/N	Genitourinary Y/N	Endocrine (glands) Y/N
Cardiovascular Y/N	Musculoskeletal Y/N	Blood/Lymph Y/N
Respiratory Y/N	Integumentary(skin) Y/N	Mental Health Y/N
Immunologic Y/N		

If yes, please explain:____
Other health problems:____

Diabetes Y/N Type: One / Two Date of diagnosis___________________
Allergies Y/N Allergic to what? ____
Describe type of allergic reaction:____
Headaches? Y/N
Are you Pregnant? (if applicable): Y/N
Current medications ____
Have you had any operations? Y/N Kind? _____________________________________
Do you use cigarettes/tobacco? _______ Alcohol?______ Other substances_________
Name of family doctor_______________________ Date of last visit_______________

Personal Eye Information

Have you had any eye operations Y/N Type __________________Date____________
Have you had any eye injury? Y/N Kind _____________________Date____________
Do you have glaucoma? Y/N cataracts? Y/N dry eyes? Y/N Blurred vision? Y/N
Other eye problems? Y/N What kind? ____
Do you wear glasses? Y/N Contact lenses? Y/N Type __________________________
Additional information____

Family History

Diabetes Y / N relation__________ Glaucoma Y/N relation_______________
High blood pressure Y / N relation_______ Macular Degeneration Y / N ___________
Cataracts Y / N relation_____________ Retinal detachment Y/N relation________
Other eye condition(s) Y/N What kind? _____________________ Relation _________