Medical and Ocular History Form

Date of last medical exam: _____ Medical Doctor: _____
Date of last eye exam: _____ Previous eye doctor: _____
Do you wear contact lenses? Yes❒ No❒ Brand of Lens? _____ Solution?_____
How often do you replace them? _____ How often do you sleep in them? _____
Are you interested in contact lenses but have been told you couldn't wear them in the past? YES NO

Personal Medical History

Do you currently have or have ever had the following conditions, check those that apply.

General Health
❒Current Pregnancy or Nursing
❒Developmental Disability
❒Cancer – Type _____
❒Tobacco Use
❒Alcohol Use
❒Drug Use

Allergic/Immunologic
❒Drug Allergy _____
❒Environmental Allergy _____
_____
❒Rheumatoid Arthritis

Cardiovascular
❒Hypertension/High Blood Pressure
❒Stroke
❒Heart Disease

Endocrine
❒Diabetes
❒Hypothyroid
❒Hyperthyroid

Neurological
❒Multiple Sclerosis
❒Epilepsy
❒Head Trauma
❒Headaches

Hematologic/Lymphatic
❒Anemia
❒Leukemia

Respiratory
❒Asthma
❒Emphysema
❒Frequent sinus infection

Eyes
❒Retinal Detachment
❒Glaucoma
❒Cataracts
❒Macular Degeneration
❒Lazy/Crossed Eye
❒Frequent Eye Infections
❒Eye Injury
❒Eye Allergies
❒Prism in glasses
❒Double Vision
❒Dry Eye

Dermatologic
❒Eczema
❒Rosacea
❒Psoriasis

Musculoskeletal
❒Muscular Dystrophy
❒Osteoarthritis
❒Ankylosing Spondylitis
❒Fibromyalgia

Psychiatric
❒Depression
❒Anxiety
❒Bipolar

Gastrointestinal
❒_____

Genitourinary
❒ _____

Ears, Nose, Throat
❒ _____

Infectious Disease
❒AIDS/HIV
❒Hepatitis
❒Tuberculosis
❒STDs _____

Other:
❒_____

Have you had any major injuries or surgeries and/or hospitalizations? Please list them.
_____
_____
_____
_____

Medications

Please list all you presently take:
_____
_____
_____
_____
_____
_____

Family History

Does any family member (parents, grandparents, siblings, and children) currently have or had any of the following conditions? Please write the relationship to you.

❒Blindness _____
❒Cataract _____
❒Crossed Eyes _____
❒Glaucoma _____
❒Macular Degeneration _____
❒Retinal Detachment _____
❒Retinal Disease _____
❒Cancer _____
❒Diabetes _____
❒Heart Disease _____
❒High Blood Pressure _____
❒Thyroid Disease _____