Classic Vision Care

Medical and Vision History

Name ________________________________ **Age** ____________

What is the primary reason for today's visit? ☐ **Blurry Vision** ☐ **Pain/Discomfort** **Other** ____________

Age of present glasses ________ **Last Eye Exam Date** ________ **From Dr.** ____________

Do you wear contact lenses? ☐ **Yes** ☐ **No** **If yes, how old is your present pair?** ____________

Do ***YOU*** or any *BLOOD RELATIVES* have:

Condition	No	Yes, who
Blindness	☐ **No**	☐ **Yes, who** ________
Cataracts	☐ **No**	☐ **Yes, who** ________
Crossed Eyes	☐ **No**	☐ **Yes, who** ________
Glaucoma	☐ **No**	☐ **Yes, who** ________
Macular Degeneration	☐ **No**	☐ **Yes, who** ________
Retinal Detach/Disease	☐ **No**	☐ **Yes, who** ________
Arthritis	☐ **No**	☐ **Yes, who** ________
Cancer	☐ **No**	☐ **Yes, who** ________
Diabetes	☐ **No**	☐ **Yes, who** ________
Heart Disease	☐ **No**	☐ **Yes, who** ________
High Blood Pressure	☐ **No**	☐ **Yes, who** ________
Kidney Disease	☐ **No**	☐ **Yes, who** ________
Lupus	☐ **No**	☐ **Yes, who** ________
Thyroid Disease	☐ **No**	☐ **Yes, who** ________
Other	☐ **No**	☐ **Yes, who** ________

Are you taking any medications? ☐ **No** ☐ **Yes, please list** ____________

____

Are you allergic to any medications? ☐ **No** ☐ **Yes, please list** ____________

____

Social History – This information is kept strictly confidential. However, you may discuss this portion with the doctor if you prefer.

☐ Yes, I prefer to discuss my Social History information with the doctor.

Question	Yes	No	Question	Yes	No
Do you drive?	☐ **Yes**	☐ **No**	If yes, do you have visual difficulty while driving?	☐ **Yes**	☐ **No**
Do you work with a computer?	☐ **Yes**	☐ **No**	Do you have trouble with night vision?	☐ **Yes**	☐ **No**
Do you drink Alcohol?	☐ **Yes**	☐ **No**	Do you use tobacco products?	☐ **Yes**	☐ **No**
Do you use illegal drugs?	☐ **Yes**	☐ **No**			

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems – Do you currently, or have you ever had any problems in the following areas?

	No	Yes	?
Constitutional			
Fever, Weight Loss/Gain	☐	☐	☐
Integumentary			
Skin	☐	☐	☐
Neurological			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Eyes			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness/Itching/Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Infection in Eye or Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
Endocrine			
Thyroid/Other Glands	☐	☐	☐

	No	Yes	?
Ear, Nose, Mouth, Throat			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Vascular/Cardiovascular			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
Gastrointestinal			
Chronic Diarrhea	☐	☐	☐
Chronic Constipation	☐	☐	☐
Genitourinary			
Genitals/Kidney/Bladder	☐	☐	☐
Bones/Joints/Muscles			
Rheumatoid Arthritis	☐	☐	☐
Muscle/Joint Pain	☐	☐	☐
Lymphatic/Hematologic			
Anemia/Bleeding Problems	☐	☐	☐
Allergic/Immunologic	☐	☐	☐
Psychiatric	☐	☐	☐

If you answered yes to any of the above, or have a condition not listed, please explain and list medications:

Dr. Initials ______

Today's Date: ____________