OCULAR AND MEDICAL REPORT

Thank you for taking your time to carefully complete the patient health information form. This information will be reviewed by Dr. Miller prior to your examination. All information provided will be held in strict confidence.

PERSONAL VISION HISTORY & FAMILIAL EYE HISTORY

When did you have your initial eye exam and were glasses prescribed? _____
When did you have your last eye exam? _____ How old are the glasses that you currently wear? _____
Have you had your pupils dilated? Y N If yes, was there any complications? _____
Does your occupation or any hobbies/recreational activities require you to use safety eyewear? Y N
Have you ever worn contact lenses? Y N Do your wear contact lenses now? Y N Type of contact lens? _____
What is your main reason for today's visit? _____

Please note any blood-related family members with the following conditions.

EYE CONDITION	YES	NO	UNSURE	RELATIONSHIP – PATERNAL OR MATERNAL
Cataracts				
Glaucoma				
Macular Degeneration				
Diabetic Retinopathy				
Crossed Eye				
Lazy Eye				
"Thick glasses"				
Other				

PERSONAL MEDICAL HISTORY & FAMILIAL MEDICAL HISTORY

Are you in good general health (if no, explain)? _____
When was your last physical exam? _____ Name & Location of Primary Physician: _____
List all current medications (names & doses) you are currently taking (prescription and over-the-counter) or if lengthy, supply and up-to-date listing for us to copy: _____
_____
Note allergies to medications/substances: _____
Note with dates major illnesses, injuries or surgeries you have had: _____
_____
Are you currently pregnant or nursing? _____

Please note any blood-realted family members with the following conditions.

MEDICAL CONDITION	YES	NO	UNSURE	RELATIONSHIP – PATERNAL of MATERNAL
Arthritis				
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
Hypercholesterolemia				
Thyroid Disease				
Other				

PERSONAL SOCIAL HISTORY

What is your occupation? _____ Do you drive most days/nights? _____
Do you use a computer at home or work (desktop, laptop, tablet or phone)? _____
List your hobbies/recreational activities: _____
Do or have you used tobacco products (type, amount, how long)? _____
Have you ever been treated for HIV: Yes/No, Alcoholism: Yes/No, Tuberculosis: Yes/No, Drug Addiction: Yes/ No

PERSONAL REVIEW OF SYSTEMS

Do you now have or have you ever been treated for any of the following health problems?

PROBLEMS	YES	NO	IF YES, PLEASE EXPLAIN
➢ Eyes / Vision			
Eye injury or eye pain			
Eye pressure - Eye headache			
Itching eyes – Burning eyes			
Sandy feeling or dry eyes			
Excessive tears (watery eyes)			
Light sensitivity - Glare			
Spots – Halos – Light flashes			
Redness or discharge			
Diabetic retinopathy			
Loss of vision			
Blurred vision (distance, intermediate or near range)			
Double vision (eye turn)			
Visual learning disability			
➢ Constitutional (continued fever, weight loss, etc.)			
➢ Ears, Nose, Mouth, Throat (sinus, chronic cough, etc.)			
➢ Respiratory (asthma, emphysema, etc.)			
➢ Cardiovascular (high blood pressure, stroke, heart disease, etc.)			
➢ Gastrointestinal (diarrhea, constipation, ulcers, etc.)			
➢ Genitourinary (genitals, kidney or bladder)			
➢ Muscles/Bones/Joints (arthritis, tendonitis, etc.)			
➢ Endocrine (diabetes, thyroid, etc.)			
➢ Psychiatric (anxiety, depression, bipolar, etc.)			
➢ Blood/Lymph (anemia, high cholesterol, etc.)			
➢ Allergic/Immunologic (hay fever, lupus, etc.)			
➢ Skin Conditions			
➢ Neurological (headaches, seizures, multiple sclerosis, etc.)			
➢ Cancer			

NAME:_____ **DATE:**_____