PROMONTORY FAMILY VISION

MEDICAL HISTORY

Patient Name: ____ Date of Birth: ______________________________

Physician's Name: _______________________________________ Physician's Phone: ___________________________

Reason for today's visit: ☐ General Eye Exam ☐ Medical office visit/Emergency ☐ Contact lens Exam

Have you been under a Physician's care within the last year? YES NO

If yes, specify what condition was being treated: ____

Please check if you have experienced any of the following eye conditions:

☐ Cataract ☐ Age Related Macular Degeneration ☐ Glaucoma ☐ Diabetic Retinopathy

☐ Diabetes ☐ Eye infection, inflammation or allergy ☐ Floaters and/ or Flashes ☐ Dry eye ☐ Iritis or Uveitis

☐ Redness ☐ Burning ☐ Itching ☐Tearing ☐ Discharge

Please check if you have any of these Vision concerns:

☐ Blurred vision ☐ Severe sensitivity to lights ☐ Bothersome night glare ☐ Headache Eye pain

☐ Eyestrain ☐ Poor night vision ☐ Total loss of vision ☐ Double vision

REVIEW OF SYSTEMS

Constitutional
☐ Developmental disabilities
☐ Cancer
☐ Fatigue syndrome
Other ________________

Psychiatric
☐ Depression
☐ Attention Deficit
☐ Anxiety
☐ Bipolar
Other ___________

ENT
☐ Hearing loss
☐ Sinusitis
☐ Dry mouth
☐ Laryngitis
Other ____________

Cardiovascular
☐ Hypertension
☐ Stroke/CVA
☐ Heart disease
☐ Vascular disease
☐ Congestive heart failure
Other _______________

Neurologic
☐ Multiple Sclerosis
☐ Epilepsy
☐ Cerebral palsy
☐ Tumor
☐ Stroke/CVA
☐ Migraine
☐ Autism
Other ____________________

Respiratory
☐ Cigarette smoker
☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Chronic obstruction
☐ Sleep apnea
Other _____________

Gastrointestinal
☐ Crohn's
☐ Colitis
☐ Ulcer
☐ Acid reflux
☐ Celiac disease
Other ___________

Genitourinary
☐ Kidney Disease
☐ Prostate/Cancer
☐ STD
☐ Benign Prostate hypertrophy
☐ Pregnancy
☐ Nursing
☐ Herpes
☐ Chlamydia
Other ______________________

Muscular/Skeletal
☐ Arthritis
☐ Osteoarthritis
☐ Fibromyalgia
☐ Muscular dystrophy
☐ Ankylosing spondylitis
☐ Herpes zoster/shingles
☐ Osteoporosis
☐ Gout
Other _____________________

Endocrine
☐ Type 2 diabetes mellitus
☐ Type 1 diabetes mellitus
☐ Thyroid dysfunction
☐ Hormonal dysfunction
Other ______________

Hematic/Lymphatic
☐ Anemia
☐ Large volume blood loss
☐ Ulcer
☐ Hypocholesteremia
Other ______________

Integumentary
☐ Eczema
☐ Rosacea
☐ Psoriasis
☐ Herpes simplex/cold sores
Other __________________

Allergy
☐ Drug Allergies
☐ Environmental allergies

Do you take any medications, pills or supplements?
If yes, list names and purpose or give our Receptionist a current copy of your list:
____
____
____
Please list any Allergies to Medications and your symptoms:
____
____

Please list Ocular surgeries you have had:
____

SOCIAL HISTORY

Do you drink alcohol? If yes, type/ amount/ how long? ______________________________
Do you use tobacco products? If yes, type/ amount/ how long? ______________________________

Family Medical History

Cancer	☐ Grandfather	☐ Grandmother	☐ Father	☐ Mother	☐ Brother	☐ Sister
Diabetes 1	☐ Grandfather	☐ Grandmother	☐ Father	☐ Mother	☐ Brother	☐ Sister
Diabetes 2	☐ Grandfather	☐ Grandmother	☐ Father	☐ Mother	☐ Brother	☐ Sister
Hypertension	☐ Grandfather	☐ Grandmother	☐ Father	☐ Mother	☐ Brother	☐ Sister
Hyperthyroidism	☐ Grandfather	☐ Grandmother	☐ Father	☐ Mother	☐ Brother	☐ Sister
Hypothyroidism	☐ Grandfather	☐ Grandmother	☐ Father	☐ Mother	☐ Brother	☐ Sister

Family Ocular History

Cataract	☐ Grandfather	☐ Grandmother	☐ Father	☐ Mother	☐ Brother	☐ Sister
Macular disorder	☐ Grandfather	☐ Grandmother	☐ Father	☐ Mother	☐ Brother	☐ Sister
Glaucoma	☐ Grandfather	☐ Grandmother	☐ Father	☐ Mother	☐ Brother	☐ Sister

Last eye exam

☐ Less than one year
☐ 1-2 years
☐ 2-5 years
☐ Over 5 years
☐ Never

Have you ever worn contact lenses?

☐ Yes
☐ No

If yes, what type?

☐ Soft
☐ Rigid gas permeable
☐ Hard

How often replaced?

☐ Yearly, or longer
☐ Every month
☐ 1-2 weeks
☐ Daily

Duration Worn

☐ Waking hours only
☐ Waking as well as sleep hours

Are you currently wearing Glasses ☐ YES ☐ NO

To my knowledge, the above information is accurate and complete.

Signature: ______________________________________ **Date:** ____________________
(Patient, Legal Guardian, or Authorized agent of Patient)