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

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

Please check if you are currently experiencing any the following:

□ Blurred vision □ Severe sensitivity to lights □ Headache Eye pain □ Double vision

□ Eyestrain □ Poor night vision/night glare □ Total loss of vision □ Tearing

□ Redness □ Burning □ Itching □ Discharge

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
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)