Medical History: circle all that apply

			Family: if yes, WHO		
Allergic Disorders	**Y**	**N**	Family	**Y**	**N**
Anemia	Y	N	Family	Y	N
Arthritis	Y	N	Family	Y	N
Asthma	Y	N	Family	Y	N
Auto Immune Disease (List type)	Y	N	Family	Y	N
Blindness	Y	N	Family	Y	N
Blood/ Lymph Disorder (List type)	Y	N	Family	Y	N
Cancer (List Type)	Y	N	Family	Y	N
Depression	Y	N	Family	Y	N
Diabetes (List Type)	Y	N	Family	Y	N
Drug sensitivity	Y	N	Family	Y	N
Epilepsy or Seizures	Y	N	Family	Y	N
Glaucoma	Y	N	Family	Y	N
Gastrointestinal Conditions (List type)	Y	N	Family	Y	N
Heart Disease/ condition (List type)	Y	N	Family	Y	N
Hepatitis (List Type)	Y	N	Family	Y	N
High blood pressure	Y	N	Family	Y	N
High cholesterol	Y	N	Family	Y	N
Kidney Disease	Y	N	Family	Y	N
Migraine Headaches	Y	N	Family	Y	N
Macular Degeneration	Y	N	Family	Y	N
Neurological Conditions (List Type)	Y	N	Family	Y	N
Psychiatric Disorder (List Type)	Y	N	Family	Y	N
Retinal Detachment	Y	N	Family	Y	N
Shingles	Y	N	Family	Y	N
Skin conditions	Y	N	Family	Y	N
Stroke	Y	N	Family	Y	N
STD or STI (List Type)	Y	N	Family	Y	N
Thyroid conditions (List type)	Y	N	Family	Y	N
Tuberculosis	Y	N	Family	Y	N

Starkville EYE CLINIC

Social History: circle all that apply

Smoke or smokeless tobacco	Y	N
Alcohol use	Y	N
Blood Transfusion	Y	N
Illegal drug use	Y	N
Females: Pregnant	Y	N
Females : Breastfeeding	Y	N

Eye History: circle all that apply

Blurry Vision Distance or near	Y	N
Burning eyes	Y	N
Cataracts	Y	N
Color vision poor	Y	N
Crossed eye	Y	N
Discharge from eyes	Y	N
Double vision	Y	N
Eye infection	Y	N
Eye injury	Y	N
Eye strain	Y	N
Fainting spells	Y	N
Floaters / Flashes	Y	N
Headaches	Y	N
Itching eyes/ watering eyes	Y	N
Light sensitive	Y	N
Loss of vision: Permanent	Y	N
Loss of vision: Intermittent	Y	N
Poor Night Vision	Y	N
Sandy/ grittiness	Y	N
Stye	Y	N
Twitching eyelid	Y	N

Medications **(list all medications you are taking , including eye drops and over the counter):**

Allergies **(**Medications or other substances):

Surgery: (list all surgeries you have had with dates)

Circle all that apply and fill in all necessary information

Do you wear glasses ?: none all the time occasionally reading driving TV

Do you have any issues with your glasses?:_____

Do you wear contacts?: Yes No Brand:_____ Wear time per day _____hrs.

Solution used:_____ rewetting drops:_____

How often do you dispose of your contacts?:_____

Do you have any issues with your contacts?:_____

My signature on this page signifies that all the above information is current and accurate.

_____ _____

Patient, Guardian , or Person Representative Date