Sterling Eye Care Medical History

Name ____ Date _______/_______/_______

Address ____ Phone ____________________

City__________________________ State ______ Zip__________ Cell Phone ____________________

Guardian (if applicable)____ Email ____________________

Birthdate ______/______/______ Last Eye Exam ______/______/______ Occupation ____________________

Do you have vision insurance? ❒ No ❒ Yes If yes, insurance carrier ______________________________

Do you have health insurance? ❒ No ❒ Yes If yes, insurance carrier ______________________________

Do you have medicare? ❒ No ❒ Yes Name of Primary Doctor ______________________________

Medical History

List medications you take (including oral contraceptives, aspirin, over-the-counter medications, and home remedies)

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Check any of the following that you have had: ❒ age-related macular degeneration ❒ inflammatory disorder
❒ cataract ❒ strabismus ❒ kerataconus ❒ amblyopia ❒ glaucoma suspect ❒ glaucoma ❒ surgery
❒ retinal degeneration/hole/detachment ❒ patching ❒ eye injury

Are you pregnant and/or nursing? ❒ No ❒ Yes

Do you wear glasses? ❒ No ❒ Yes If yes, how old is your present pair of lenses? ____________________

Do you wear contact lenses? ❒ No ❒ Yes If yes, what brand? ______________________________

Type of contact lenses: ❒ Rigid ❒ Soft How often do you replace them? ____________ Are they comfortable? ❒ No ❒ Yes

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	**Yes**	**No**	**?**	**Relationship**
Thyroid Disease	❒	❒	❒	____________________
Diabetes	❒	❒	❒	____________________
Hypertension	❒	❒	❒	____________________
Cancer	❒	❒	❒	____________________
Strabismus	❒	❒	❒	____________________
Cataract	❒	❒	❒	____________________
Glaucoma Suspect	❒	❒	❒	____________________
Amblyopia	❒	❒	❒	____________________
Severe Myopia	❒	❒	❒	____________________
Macular Degeneration	❒	❒	❒	____________________
Retinal Detachment/Disease	❒	❒	❒	____________________
Glaucoma	❒	❒	❒	____________________
Severe Hyperopia	❒	❒	❒	____________________
Other	❒	❒	❒	____________________

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

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

Do you drive? ❒ No ❒ Yes If yes, do you have visual difficulty when driving? ❒ No ❒ Yes If yes, please describe:

____

Do you use tobacco products? ❒ No ❒ Yes If yes, type/amount/how long ______________________________

Are you a ❒ Former Smoker ❒ Current Occasional Smoker ❒ Current Everyday Smoker

Do you drink alcohol? ❒ No ❒ Yes If yes, type/amount/how long ______________________________

Do you use illegal drugs? ❒ No ❒ Yes If yes, type/amount/how long ______________________________

Previous Eye Care Provider________________________________ Date of Last Eye Exam______________________________

Review of Systems

Do you currently, or have you ever had, any problems in the following areas:

	Yes	No
Eyes		
Itching	❒	❒
Diplopia	❒	❒
Burning	❒	❒
Mattering	❒	❒
Loss of Vision	❒	❒
Photophobia	❒	❒
Red	❒	❒
Floaters	❒	❒
Loss of Sharpness	❒	❒
Flashes	❒	❒
Tearing	❒	❒
Other______________________		
Constitutional		
Developmental Disorders	❒	❒
Cancer	❒	❒
Fatigue Syndrome	❒	❒
Other______________________		
Ear, Nose, Mouth, Throat		
Sinusitus	❒	❒
Dry Mouth	❒	❒
Hearing Loss	❒	❒
Laryngitis	❒	❒
Other______________________		
Neurological		
Epilepsy	❒	❒
Multiple Seizures	❒	❒
Tumor	❒	❒
Cerebral Palsy	❒	❒
Stroke/CVA	❒	❒
Migraine	❒	❒
Other______________________		
Psychiatric		
Depression	❒	❒
Bipolar	❒	❒
Anxiety	❒	❒
Attention Deficit	❒	❒
Other______________________		
Vascular/Cardiovascular		
Vascular Disease	❒	❒
Stroke	❒	❒
Heart Disease	❒	❒
High Blood Pressure	❒	❒
Congestive Heart Failure	❒	❒
Other______________________		
Respiratory		
Cigarette Smoker	❒	❒
Bronchitis	❒	❒
COPD	❒	❒
Emphysema	❒	❒
Asthma	❒	❒

	Yes	No
Respiratory (continued)		
Sleep Apnea	❒	❒
Other______________________		
Gastrointestinal		
Celiac Disease	❒	❒
Crohn's Disease	❒	❒
Ulcer	❒	❒
Colitis	❒	❒
Acid Reflux	❒	❒
Other______________________		
Genitourinary		
Kidney Disease	❒	❒
STD - Herpetic/Chlamydia	❒	❒
Prostate Disease/Cancer	❒	❒
Pregnant/Nursing	❒	❒
Other______________________		
Musculoskeletal		
Arthritis	❒	❒
Ankylosing Spondylitis	❒	❒
Fibromyalgia	❒	❒
Muscular Dystrophy	❒	❒
Osteoarthritis	❒	❒
Gout	❒	❒
Other______________________		
Integumentary		
Herpes Simplex/Cold Sores	❒	❒
Herpes Zoster/Shingles	❒	❒
Rosacea	❒	❒
Psoriasis	❒	❒
Eczema	❒	❒
Other______________________		
Endocrine		
Diabetes Type II	❒	❒
Thyroid Dysfunction	❒	❒
Hormonal Dysfunction	❒	❒
Diabetes Type I	❒	❒
Other______________________		
Hematologic/Lymphatic		
Large Volume Blood Loss	❒	❒
Anemia	❒	❒
Ulcer	❒	❒
High Cholesterol	❒	❒
Other______________________		
Allergic/Immunologic		
Environmental Allergies	❒	❒
Lupus	❒	❒
Rheumatoid Arthritis	❒	❒
Drug Allergies	❒	❒
If yes, what drug?__________________		
Sjogrens Syndrome	❒	❒
Other______________________		

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

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Doctor's Signature____ Date ______/______/______