

## Eyes Nouveau - Medical History

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Do you wear glasses ? <input type="checkbox"/> yes <input type="checkbox"/> no	Do you need new glasses ? <input type="checkbox"/> yes <input type="checkbox"/> no
Do you wear contact lenses ? <input type="checkbox"/> yes <input type="checkbox"/> no	Do you want us to fit you in contact lenses today ? <input type="checkbox"/> yes <input type="checkbox"/> no
Are you interested in Lasik ? <input type="checkbox"/> yes <input type="checkbox"/> no	Do you have visual difficulty when you drive ? <input type="checkbox"/> yes <input type="checkbox"/> no

◆ **If you or a family member has a history of the following conditions, Please check the appropriate box.**

	Patient	Family		Patient	Family		Patient	Family		Patient	Family
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Drooping Eyelid	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Prominent Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
									Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>

Are you **allergic** to any medications?     yes     no - If yes, please explain \_\_\_\_\_

List any medications you take and the reason you take them (including contraceptives and over the counter medications). \_\_\_\_\_

List all major injuries, surgeries and/or hospitalizations you have had: \_\_\_\_\_

◆ **Social History** - This information is kept strictly confidential. However, you may discuss this portion directly with your doctor if you prefer by checking this box.   

Do you use tobacco products ?     yes     no - If yes, type / amount / how long: \_\_\_\_\_

Do you drink alcohol ?     yes     no - If yes, type / amount / how long: \_\_\_\_\_

Do you use illegal drugs ?     yes     no - If yes, type / amount / how long: \_\_\_\_\_

Have you ever been exposed to or infected with:     Hepatitis     HIV     Syphilis

◆ **Do you currently have any problems or conditions in the following areas:**

	Yes	No		Yes	No		Yes	No		Yes	No
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Floaters-Recent Onset	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	Redness of the Eye	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>	Sandy/Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Genitals	<input type="checkbox"/>	<input type="checkbox"/>
Recent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Itching Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant &/or Nursing	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Burning Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Infection of	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Flashes of Light	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems	<input type="checkbox"/>	<input type="checkbox"/>

◆ **If you answered YES to any of the above or have a condition not listed, please explain and list medications:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If necessary, it is **OK** to dilate my eyes today.    OR     Please **DO NOT** dilate my eyes today.

Patient Signature \_\_\_\_\_ Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_