Curtis Optometry Group

Medical History

Name: _____ Date: _____

Email: _____ Birth Date: _____

Last Eye Exam *(date)*: _____

Last Medical Exam *(date)*: _____ Last Medical Doctor *(name)*: _____

Patient Ocular/Medical History

	Yes	No
Glaucoma		
Cataracts		
Macular Degeneration		
Eye Injury		
Retinal Disease		
Loss of Vision/Blindness		
Eye Turn/Strabismus		
Lazy Eye/Amblyopia		
Eye Infection		
Dry Eye		
High Blood Pressure/Hypertension		
Diabetes		
Other Disease(s)/Prematurity		
Do you wear glasses?		
Do you wear contact lenses?		
If NO, would you like to?		
Have you ever had a **surgery** on your eyes?		

If YES, what was it? Why did you have it performed?

_____

Family Ocular/Medical History

	Relation	Yes	No
Glaucoma			
Cataracts			
Macular Degeneration			
Eye Injury			
Retinal Disease			
Loss of Vision/Blindness			
Eye Turn/Strabismus			
Lazy Eye/Amblyopia			
Eye Infection			
Dry Eye			
High Blood Pressure/Hypertension			
Diabetes			
Other Disease(s)/Prematurity			

Social History

	Yes	No
Do you smoke?		
If YES, do you smoke every day?		
If NO, did you used to smoke?		
Do you use recreational drugs		
Do you drink alcohol?		
Are you currently pregnant or nursing?		

What is your occupation?

What are your hobbies?

How many hours a day do you use a computer?

What is your current height?

What is your current weight?

Patient Review of Health

Do you currently have or ever had problems in the following areas?

	Yes	No
Constitution *(Fever, Weight Gain/Loss)*		
Cardiovascular/Vascular *(Diabetes, High Blood Pressure, Stroke)*		
Ears, Nose, Throat, Mouth *(Allergies, Sinus Congestion, Dryness)*		
Respiratory *(Asthma, Bronchitis, Emphysema)*		
Gastrointestinal *(Diarrhea, Constipation)*		
Genitourinary *(Genitals, Kidney, Bladder Problems)*		
Musculoskeletal *(Arthritis, Joint/Muscle Pain)*		
Integumentary *(Skin Problems)*		
Neurological *(Headaches, Migraines, Seizures)*		
Psychiatric *(Mental/Emotional Problems)*		
Endocrine *(Thyroid/Other Gland Problem)*		
Hematologic/Lymphatic *(Anemia, Bleeding Problems)*		
Allergic/Immunologic *(Allergy)*		

Medications

List all medications that you currently take (including over-the-counter, vitamins, supplements, oral contraceptives, etc.)

_____

_____

_____

What is your preferred pharmacy? _____ Phone Number: _____

Do you have any allergies to medications? _____

Do you have environmental allergies? _____