**Montague Eye Center – Health History**

**PATIENT’S NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient’s Primary Medical Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Personal Medical History** - Select all which you have or ever had problems with, if none select none in each category

**Allergies Cardiovascular Constitutional Endocrine Gastrointestinal**

  Drug Allergies  Heart Attack/Stroke  Weakness  Diabetes  Reflux

  Food Allergies  Vascular Disease  Weight Loss/Gain  Thyroid  Cancer

  Seasonal Allergies  High Blood Pressure  Other  Pituitary  Ulcer

  Other  High Cholesterol  None  Other  Other

  None  Other  None  None

  None

 **Genitourinary Head Hematologic/Lymphatic Immunologic Integumentary/skin**

 Ovarian Cancer  Hearing Loss  Anemia  AIDS  Acne

  Kidney Disease  Sinus Congestion  Bleeding Problems  HIV Positive  Rosacea

  Prostate Cancer  Chronic Cough  Leukemia  Herpes Zoster  Skin Cancer

  STD  Runny Nose  Other  Other  Other

  Other  Dry Throat/ Mouth  None  None  None

  None  Other

  None

**Bones/Joints Muscles Neurological Psychiatric Respiratory Social History**

  Arthritis  Headaches  Attention Disorder  Asthma *Do you use/drink*

  Muscle Pain/Weak  Migraines  Anxiety  Chronic Bronchitis  Tobacco Products

  Joint Pain  Seizures  Depression  Emphysema  Alcohol

  Other  Head Injury  Other  Lung Cancer  Illegal Drugs

  None  Other  None  Other

  None  None

 **List all medications you are currently taking: List all medications you are allergic to:**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Are you pregnant or nursing:**  Yes  No

 **Personal Ocular History** - Select all which you have or ever had problems with

  Sudden Loss of Vision (not blur)  Styes or Chalazion  Flashes of Light  Floaters in Vision

  Chronic Infection of Eye or Lid  Itching  Tired Eyes  Lasik Surgery

  Blurred Vision  Burning  Redness  Cataract Surgery

  Distorted Vision  Computer Strain  Glaucoma  Other Eye Surgery

  Double Vision  Excess Tearing/ Watering  Mucous Discharge

  Dryness  Glare/ Light Sensitivity  Cataracts

  Sandy/ Gritty Feeling  Eye Pain or Soreness  Macular Degeneration

  Other – Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Do you wear contacts:**  Current  Never  Wore in the Past

**Are you interested in the latest developments in Contact Lenses:**  Yes  No

 **Family Medical and Ocular History** - Select all which apply to your family

  Blindness  Crossed Eyes  Glaucoma

  Thyroid Disease  Cataracts  Retinal Disease

  Macular Degeneration  Retinal Detachment  Lupus

  Diabetes  Kidney Disease  High Blood Pressure

  Heart Disease  Cancer  None

  Other – Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Patient or Responsible Party**