**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**