VisionCare Specialists Medical History Form

Name:____ Date of Birth:_______________

What is the main reason for your visit today?_______________________________________

Please check if you are experiencing any of the following:

Dry eyes	Blur at Distance	Glare
Red eyes	Blur at Near	Floaters
Itchy eyes	Blur at Computer	Vision Loss
Irritated eyes	Eye strain	Other:

Please check if **<u>you or anyone in your family</u>** has ever experienced the following eye problems:

	Yourself	Family		Yourself	Family
Cataracts			Lazy eye		
Cataract surgery			Eye turn		
Glaucoma			Eye turn surgery		
Macular Degeneration			Eye trauma		
Retinal Detachment			Keratoconus		
Diabetic retinopathy			Other:_________________________		

Have **<u>you or anyone in your family</u>** ever been diagnosed with or have had a significant problem with:

	Yourself	Family		Yourself	Family
High blood pressure			Headaches/Migraines		
Diabetes			Arthritis		
Heart disease			Mental health		
High cholesterol			Currently pregnant		
Stroke			Smoking		
Cancer					
Type(s)_________________________			Other: _____________________________		

Please list any allergies (environmental or medication) that you may have:

_________________________ _________________________ _________________________

Please give a complete list of medications that you are currently taking:

Medication	Reason taken (if known)	Dosage (if known)
___________________________	___________________________	___________________________
___________________________	___________________________	___________________________
___________________________	___________________________	___________________________
___________________________	___________________________	___________________________