Medical History (If you are filling this page out for your child, provide information pertaining to them.)

Although we primarily treat the area in and around the eye, one's eye is a part of the entire body. Previous health problems and/or medications could have an important interrelationship with your eye's health. Please answer each of the following questions as completely as possible. **Thank You!**

Patient Name _____ Patient Date of Birth _____

- Has your child ever been hospitalized for any reason? No ( ) Yes ( ) If yes please explain _____
- Has your child ever had a serious head or neck injury? No ( ) Yes ( ) If yes please explain _____
- Is the patient currently pregnant or nursing? No ( ) Yes ( ) If yes please explain _____

- Does your child have, or ever had, any of the following?

( ) AIDS/HIV Positive	( ) Developmental Disability	( ) Frequent Headaches	( ) Hypoglycemia	( ) Prostate Disease
( ) Alzheimer's Disease	( ) Depression	( ) Gout	( ) Hyperthyroid	( ) Psychiatric Care
( ) Anaphylaxis	( ) Diabetes	( ) Hay Fever	( ) Hypothyroid	( ) Recent Weight Loss
( ) Arthritis	( ) Dry Mouth	( ) Hearing Loss	( ) Kidney Disease	( ) Rosacea
( ) Asthma	( ) Emphysema	( ) Heart Attack/Failure	( ) Learning Disability	( ) Shingles
( ) Blood/Bleeding Disorder	( ) Epilepsy or Seizures	( ) Heart Trouble/Disease	( ) Leukemia	( ) Sinus Trouble
( ) Breathing Problems	( ) Excessive Thirst	( ) Hepatitis A, B, or C	( ) Liver Disease	( ) Stomach Disease
( ) Cancer	( ) Fainting Spells/Dizziness	( ) Herpes	( ) Low Blood Pressure	( ) Stroke
( ) Cerebral Palsy	( ) Frequent Cough	( ) High Cholesterol	( ) Lung Disease	( ) Tuberculosis
( ) Chicken Pox	( ) Frequent Diarrhea	( ) High Blood Pressure	( ) Multiple Sclerosis	( ) Tumors or Growths
( ) Cold Sores/Fever Blisters	( ) Fatigue Syndrome	( ) Hives Rash	( ) Osteoarthritis	( ) Ulcers

Allergies

- Is your child allergic to any of the following?

( ) Aspirin ( ) Penicillin ( ) Amoxicillin ( ) Sulfa ( ) Codeine ( ) Local Anesthetic ( ) Pollen ( ) Pet Dander ( ) Latex

Please list any other allergies not listed above:

Medications

- Is your child taking any medications, pills, or drugs? Yes ( ) No ( ) Please list current medications, including non-prescription:

Ocular History

- Has your child had any eye surgeries? No ( ) Yes ( ) If yes please explain _____
- Does your child currently wear glasses? No ( ) Yes ( ) If yes please explain _____
- Does your child currently wear contact lenses? No ( ) Yes ( ) If yes please explain _____
- When was your child's last eye exam?_____ Where: _____
- Does your child have, or ever had, any of the following

( ) Crossed Eye/ Lazy Eye ( ) Corneal Disease ( ) Injury/Trauma ( ) Retinal Disease ( ) Retinal Detachment ( ) Cataracts ( ) Glaucoma

( ) Macular Degeneration ( ) Diabetic Retinopathy ( ) Red eye ( ) Dry/Burning Eyes ( ) Retinitis Pigmentosa ( ) Itchy Eye ( ) Iritis

Please list any other eye problems not listed above:

Family History

- Does anyone in your family (blood relative) have, or ever had, any of the following?

* (Note relation to patient: M- Mother, F- Father, U- Uncle, A- Aunt, S- Sister, B- Brother, GF- Grandfather, GM- Grandmother)

( ) Glaucoma _____ ( ) Cataracts_____ ( ) Cornea Disease_____

( ) Macular Degeneration_____ ( ) Diabetic Retinopathy_____ ( ) Retinal Detachment_____

( ) Retinitis Pigmentosa_____ ( ) Crossed/Lazy Eye_____ ( ) Diabetes_____

( ) Heart Conditions_____ ( ) High Blood Pressure_____

Please list any other family health or eye problems:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or my child's) health. It is my responsibility to inform the vision office of any changes in my (or my child's) medical status. I also authorize the vision staff to perform the necessary vision services I (or my child) may need.

_____ _____ _____ _____

Signature of Patient (or parent/guardian if minor) Date Optometrist Review Date