EYE CENTER OF GRAND RAPIDS

Medical History Form

Patient Name: _____ **Date of Birth**: _____

Please complete this form as fully and accurately as possible. Circle from the available options if applicable.

Ocular History (Have you had any of the following? If yes, **specify what type, which eye, and when**)

Eye injury (painful, bloody,or affected vision)	NO	YES	_____
Eye or eyelid surgery or procedure(s)	NO	YES	_____
Eye laser treatment(s)	NO	YES	_____
"Lazy eye" or patching during childhood	NO	YES	_____
Glaucoma or high eye pressure	NO	YES	_____
Cataract	NO	YES	_____
Uveitis, iritis, or inflammation	NO	YES	_____
Retinal, corneal, or optic nerve problems	NO	YES	_____
Contact lens wear	NO	YES	_____

Current Eye Medications (list **name of drop**, **which eye**, and **how often**; include artificial tears and OTC's)

_____ _____

_____ _____

_____ _____

Current Eye Symptoms (Do you have any of the following? If yes, **specify what, which eye, and since when**)

Harder to see or read at distance or near	NO	YES	_____
Glare or halos at night or in bright light	NO	YES	_____
Floaters or flashing lights	NO	YES	_____
Dry eye, irritation, burning, or itching	NO	YES	_____
Watering, tearing, mucus discharge	NO	YES	_____
Pain, discomfort, light sensitivity	NO	YES	_____
Double vision	NO	YES	_____
Eyelid swelling or drooping or bump	NO	YES	_____
Dimming or black-out of vision	NO	YES	_____

Family History (Any relatives with the following?) If so, **specify condition** & **list relationship** (sister, dad, etc)

Glaucoma	NO	YES	_____
Macular degeneration	NO	YES	_____
Blindness or hereditary eye problem	NO	YES	_____
(Circle) Heart disease, stroke,	NO	YES	(who?)_____
high blood pressure, cancer, other)	☐ Check the box if you do not know your family medical history		

Social History

Current tobacco smoking?	NO	YES	I currently / used to	smoke ___ packs per day for ____ years.
Current alcohol use?	NO	YES	I currently / used to	drink ___ drinks per day, __ days a week.
Current street drug use?	NO	YES	I currently / used to	use _____

Occupation and/or other activities (please specify frequent work or leisure related activities such as computer use, reading, sports, gardening, watching television, traveling, swimming, heavy lifting, driving)

_____

Does anyone live with you at home? NO YES _____

Allergies **Drug Name** **Reaction Type**

Do you have any medication allergies? NO YES _____ _____

_____ _____

_____ _____

Environmental/Seasonal/Food allergies NO YES _____

Current Non-Ocular Medications (including inhalers, patches, over the counter meds, and vitamins or supplements)

Drug Name/Type	**Dose (mg or mcg or ml)**	**How often used**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

General Medical History (if yes, please **specify what and when**)

Have you ever been hospitalized or had major operations? NO YES _____

*__When/what__:_____

Have you ever had serious head/face trauma or fractures? NO YES _____

Any severe blood loss or blood pressure drop? NO YES _____

Are you (or could you possibly be) pregnant now? NO YES _____

Do you have any of the following medical problems or symptoms? (if yes, **specify what and since when**)

Diabetes NO YES _____

Blood pressure (high or very low) NO YES_____

Heart disease NO YES _____

Thyroid problems NO YES _____

Stroke or mini-stroke NO YES _____

Lung or breathing problems NO YES _____

Sleep apnea NO YES *If so, do you use CPAP? NO YES _____

Ear/nose/mouth/throat problems NO YES _____

Headache or dizziness NO YES _____

Neuro problems, numbness, weakness NO YES _____

Fever, fatigue, weight loss NO YES _____

Gastrointestinal problems NO YES _____

Muscle, bone, or joint problems NO YES _____

Skin problems NO YES _____

Blood or bleeding problems NO YES _____

Genital/urinary or kidney problems NO YES _____

Immunologic/rheumatologic problems NO YES _____

Psychological problems NO YES _____

Cancer NO YES _____

Other NO YES _____