Eyes Nouveau - Medical History

Name _____ Today's Date _____

Do you wear glasses ?	❒ yes	❒ no	Do you need new glasses ?	❒ yes	❒ no
Do you wear contact lenses ?	❒ yes	❒ no	Do you want us to fit you in contact lenses today ?	❒ yes	❒ no
Are you interested in Lasik ?	❒ yes	❒ no	Do you have visual difficulty when you drive ?	❒ yes	❒ no

♦ If you or a family member has a history of the following conditions, Please check the appropriate box.

	Patient	Family		Patient	Family		Patient	Family		Patient	Family
Blindness	❒	❒	Drooping Eyelid	❒	❒	Retinal Detatchment	❒	❒	Heart Disease	❒	❒
Cataracts	❒	❒	Prominent Eyes	❒	❒	Arthritis	❒	❒	High Blood Pressure	❒	❒
Crossed Eyes	❒	❒	Glaucoma	❒	❒	Cancer	❒	❒	Kidney Disease	❒	❒
Lazy Eye	❒	❒	Macular Degeneration	❒	❒	Diabetes	❒	❒	Lupus	❒	❒
									Thyroid Disease	❒	❒

Are you **allergic** to any medications? ❒ yes ❒ no - If yes, please explain _____

List any medications you take and the reason you take them (including contraceptives and over the counter medications). _____

List all major injuries, surgeries and/or hospitalizations you have had: _____

♦ Social History - This information is kept strictly confidential. However, you may discuss this portion directly with your doctor if you prefer by checking this box. ❒

Do you use tobacco products ? ❒ yes ❒ no - If yes, type / amount / how long: _____

Do you drink alcohol ? ❒ yes ❒ no - If yes, type / amount / how long: _____

Do you use illegal drugs ? ❒ yes ❒ no - If yes, type / amount / how long: _____

Have you ever been exposed to or infected with: ❒ Hepatitis ❒ HIV ❒ Syphilis

♦ Do you currently have any problems or conditions in the following areas:

	Yes	No		Yes	No		Yes	No		Yes	No
Fever	❒	❒	Mucous Discharge	❒	❒	Floaters-Recent Onset	❒	❒	Chronic Diarrhea	❒	❒
Weight Loss/Gain	❒	❒	Redness of the Eye	❒	❒	Thyroid/Other Glands	❒	❒	Chronic Constipation	❒	❒
Skin Problems	❒	❒	Sandy/Gritty Feeling	❒	❒	Allergies/Hay Fever	❒	❒	Genitals	❒	❒
Recent Headaches	❒	❒	Itching Eyes	❒	❒	Chronic Congestion	❒	❒	Pregnant &/or Nursing	❒	❒
Migraines	❒	❒	Burning Eyes	❒	❒	Chronic Cough	❒	❒	Kidney	❒	❒
Seizures	❒	❒	Excess Tearing/Watering	❒	❒	Dry Throat/Mouth	❒	❒	Bladder	❒	❒
Blurred Vision	❒	❒	Glare/Light Sensitivity	❒	❒	Asthma	❒	❒	Rheumatoid Arthritis	❒	❒
Loss of Vision	❒	❒	Eye Pain or Soreness	❒	❒	Chronic Bronchitis	❒	❒	Chronic Muscle Pain	❒	❒
Distorted Vision/Halos	❒	❒	Chronic Infection of			Emphysema	❒	❒	Chronic Joint Pain	❒	❒
Loss of Side Vision	❒	❒	Eye or Lid	❒	❒	Heart Disease	❒	❒	Anemia	❒	❒
Double Vision	❒	❒	Eye Injury	❒	❒	High Blood Pressure	❒	❒	Bleeding Problems	❒	❒
Dryness	❒	❒	Flashes of Light	❒	❒	Vascular Disease	❒	❒	Psychiatric Problems	❒	❒

♦ If you answered YES to any of the above or have a condition not listed, please explain and list medications:

❒ If necessary, it is **OK** to dilate my eyes today. OR ❒ Please **DO NOT** dilate my eyes today.

Patient Signature _____ Doctor's Signature _____ Date _____