Chart # _____

Salina Family Healthcare Center – Eyecare Medical History

The following information helps us take better care of you. All information obtained is handled in a private and confidential manner. Any blank will be considered a "declined to comment."

Patient Name: Today's Date: / / Date of Birth: / /

Last Eye Doctor: Last Eye Exam: / /

Current Primary Care Provider: Last Medical Exam: / /

What is your reason for seeking Vision Care at this time: _____

_____

Medical History

Do you consider your health: Good Fair Poor Are you pregnant: Yes No

Height: Feet Inches Weight:

Are you currently taking any medications or drugs: Yes No If yes, what are you taking?

_____

_____

Are you allergic to any medications or drugs? Yes No If yes, which drugs?

Drug	Reaction	Severity		
_____	_____	Low	Medium	High
_____	_____	Low	Medium	High
_____	_____	Low	Medium	High

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

_____

_____

What is your current form of vision correction: Glasses Contacts Glasses/Contacts None

Have you ever worn contact lenses: Yes No Are you interested in contact lenses? Yes No

If you wear contacts, what type of contacts do you wear? Rigid Soft Extended Wear

Do you wear prescription sunglasses? Yes No Do you wear glasses for computer work? Yes No

Social History

Do you drive? Yes No If yes, do you have visual difficulty driving? Yes No

If yes, please describe: _____

If you are over 13, do you smoke? Never Former Some Days Every Day

If a smoker, number of cigarettes smoked per day? _____

Do you drink alcohol? Yes No If yes, type/amount/how long: _____

Do you use recreational drugs? Yes No If yes, type/amount/how long: _____

Have you ever been exposed/infected with: Gonorrhea Hepatitis HIV Syphilis No, I have not

Chart # _____

Family History

Have any of your parents, siblings, or children had any of the following conditions? Please circle.

Ocular Disease/Condition	Yes	No	Relationship to You					
Blindness	Yes	No	Mother	Father	Sister	Brother	Daughter	Son
Cataract	Yes	No	Mother	Father	Sister	Brother	Daughter	Son
Glaucoma	Yes	No	Mother	Father	Sister	Brother	Daughter	Son
Macular Degeneration	Yes	No	Mother	Father	Sister	Brother	Daughter	Son
Retinal Detachment/Disease	Yes	No	Mother	Father	Sister	Brother	Daughter	Son

Systemic Disease/Condition	Yes	No	Relationship to You					
Arthritis	Yes	No	Mother	Father	Sister	Brother	Daughter	Son
Asthma	Yes	No	Mother	Father	Sister	Brother	Daughter	Son
Cancer	Yes	No	Mother	Father	Sister	Brother	Daughter	Son
Diabetes	Yes	No	Mother	Father	Sister	Brother	Daughter	Son
Heart Disease	Yes	No	Mother	Father	Sister	Brother	Daughter	Son
High Blood Pressure	Yes	No	Mother	Father	Sister	Brother	Daughter	Son
Kidney Disease	Yes	No	Mother	Father	Sister	Brother	Daughter	Son
Thyroid Disease	Yes	No	Mother	Father	Sister	Brother	Daughter	Son
Other: _____	Yes	No	Mother	Father	Sister	Brother	Daughter	Son

Review of Symptoms: Do you currently or have you ever had any problems in the following areas? Please circle.

Cancer	Yes	No	Not Sure	**Mental Health**	Yes	No	Not Sure
Constitutional				**Ears, Nose, Mouth, Throat**			
Fever/Weight Loss/Gain	Yes	No	Not Sure	Allergies/Hay Fever	Yes	No	Not Sure
Nuerological				Sinus Congestion	Yes	No	Not Sure
Headaches	Yes	No	Not Sure	Chronic Cough	Yes	No	Not Sure
Migraines	Yes	No	Not Sure	Dry Throat/Mouth	Yes	No	Not Sure
Seizures	Yes	No	Not Sure	Ear Ache	Yes	No	Not Sure
Eyes				**Respiratory**			
Loss of Vision	Yes	No	Not Sure	Asthma	Yes	No	Not Sure
Blurred Vision	Yes	No	Not Sure	Chronic Bronchitis	Yes	No	Not Sure
Distorted Vision	Yes	No	Not Sure	Emphysema	Yes	No	Not Sure
Loss of Side Visio	Yes	No	Not Sure	**Vascular/Cardiovascular**			
Double Vision	Yes	No	Not Sure	Diabetes	Yes	No	Not Sure
Dryness	Yes	No	Not Sure	Duration:		Last Hba1c:	
Mucous Discharge	Yes	No	Not Sure	High Blood Pressure	Yes	No	Not Sure
Redness	Yes	No	Not Sure	Vascular Disease	Yes	No	Not Sure
Sandy/Gritty	Yes	No	Not Sure	Brain Injury/Stroke	Yes	No	Not Sure
Itching	Yes	No	Not Sure	**Gastrointestinal**			
Burning	Yes	No	Not Sure	Diarrhea	Yes	No	Not Sure
Foreign Body Sensation	Yes	No	Not Sure	Constipation	Yes	No	Not Sure
Excess Tearing/Watering	Yes	No	Not Sure	Ulcers	Yes	No	Not Sure
Glare/Light Sensitivity	Yes	No	Not Sure	**Genitourinary**			
Eye Pain/Soreness	Yes	No	Not Sure	Genitals/Kidney/Bladder	Yes	No	Not Sure
Chronic Infection	Yes	No	Not Sure	**Bones/Joints/Muscles**			
Sty/Chalazion	Yes	No	Not Sure	Rheumatoid Arthritis	Yes	No	Not Sure
Flashes/Floaters	Yes	No	Not Sure	Muscle Pain	Yes	No	Not Sure
Tired Eyes	Yes	No	Not Sure	Joint Pain	Yes	No	Not Sure
Endocrine				**Lymphatic/Hematologic**			
Thyroid	Yes	No	Not Sure	Anemia	Yes	No	Not Sure
Skin (Integumentary)	Yes	No	Not Sure	Bleeding Problems	Yes	No	Not Sure
Allergic/Immunologic	Yes	No	Not Sure				