Medical History – Confidential

Name________________________________ Date of birth ____ /____ /____ Gender M F Date ____ /____ /____
Address__________________________________ City___________________ State________ Zip_________ Age ______
Home Phone/ Cell Phone _________________________________ Occupation ________________________________
Email _____________________________

Personal Health History: Please circle Y or N if you have or had any of the following: Y=Yes N=No

High Blood Pressure	Y N	Diabetes	Y N	High Cholesterol	Y N	Cancer	Y N
Thyroid Disease	Y N	Arthritis	Y N	Heart Disease	Y N	Stroke	Y N
Kidney Disease	Y N	Seizures	Y N	Liver Disease	Y N	Cataracts	Y N
Lazy Eye/Eye Turn	Y N	Glaucoma	Y N	Eye Injury	Y N	Eye Surgery	Y N
Macular Degeneration	Y N	Retinal Disease or Detachments			Y N		

List all medications you are currently taking including over the counters and vitamins_______________________
____
Do you have any allergies, including medications? Y N If yes, please explain ____________________________
Height________ Weight___________ Blood Pressure ____________
For women, are you pregnant? Y N Are you nursing? Y N
Do you wear glasses? Y N If yes, how old are your glasses? ________________
Do you wear contact lenses? Y N If yes, what type (Disposables, Extended Wear, Rigid Gas Permeable)?

Family Health History: Please circle Y or N if a blood relative has or had any of the following. Please indicate which family member: M=Mother F=Father S=Sibling G=Grandparent A=Aunt/Uncle

High Blood Pressure	Y____ N	Diabetes	Y____ N	Cancer	Y____ N	Arthritis	Y____ N
Heart Disease	Y____ N	Cataracts	Y____ N	Glaucoma	Y____ N	Blindness	Y____N
Macular Degeneration	Y____N	Retinal Disease or Detachments	Y____ N				

Review of Systems: Please circle Y or N if you have or had any problems in the following areas

Eyes: Redness Y N Blurred Vision Y N Tearing Y N Glare/Halos Y N Itchy Eyes Y N
Dry Eyes Y N Flashes/Floaters Y N Burning Y N Discharge Y N Eye Strain Y N
Chronic Infections Y N Light Sensitivity Y N

Ears, Nose, Throat:		***Skin:***		***Neurological:***		***Cardiovascular:***	
Sinusitis	Y N	Eczema	Y N	Migraines	Y N	Chest Pains	Y N
Dry Mouth	Y N	Roseacea	Y N	Epilepsy	Y N	Blood Clots	Y N
Ear Ache	Y N	Psoriasis	Y N	Multiple Sclerosis	Y N	Vascular Disease	Y N
Immunological:		***Psychiatric:***		***Hematologic/Lymphatic***		***Muscular/Skeletal***	
Lupus	Y N	Depression	Y N	Anemia	Y N	Joint Pain	Y N
Rheumatoid Arthritis	Y N	Bi-polar	Y N	Leukemia	Y N	Fibromyalgia	Y N
		Schizophrenia	Y N	Bleeding Disorder	Y N	Muscle Pain	Y N
Respiratory:		***Gastrointestinal:***		***General Health:***		***Genitourinary:***	
Asthma	Y N	Crohn's Disease	Y N	Weight Loss/Gain	Y N	HIV	Y N
Emphysema	Y N	Ulcer	Y N	Chronic Fever	Y N	UTI	Y N
Bronchitis	Y N	Digestive	Y N	Fatigue	Y N	STD	Y N

Social History
Do you participate in sports and/or have any hobbies? Y N If yes, which ones? ___________________________
How many hours are you on the computer? _____________________________________
Do you smoke? Y N If so, how much? ________ Do you consume alcohol? Y N If so, how much?_________

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I acknowledge that I have received a copy of Smart Optical's Notice of Privacy Practices.
Patient's/Legal Guardian's Signature____