Medical History - New Patient

NCT OD:____
OS:____ **Date:** _____

Optomap: Yes_____ No_____ **Age:** _____

What is the reason for your visit today? _____

Currently taking medication(s) - (prescription and over-the-counter) Yes No

1._____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Drug Allergies Yes No
If YES, Please list the medications:

List all eye injuries: _____

List any eye surgeries you have had: _____

_____

EYES (Current or Existing Problems Associated With)

Loss of Vision	Yes	No	Sandy or Gritty Feeling	Yes	No
Blurred Vision (Near)	Yes	No	Glaucoma	Yes	No
Blurred Vision (Distant)	Yes	No	Itching	Yes	No
Fluctuating Vision	Yes	No	Burning	Yes	No
Loss of Side Vision	Yes	No	Excess Tearing/Watering	Yes	No
Double Vision	Yes	No	Glare/Light Sensitivity	Yes	No
Dryness	Yes	No	Infection of Eye or Eyelid (blepharitis/stye)	Yes	No
Mucous Discharge	Yes	No	Tired Eyes	Yes	No
Redness	Yes	No	Crossed Eyes/Lazy Eye	Yes	No

REVIEW OF SYSTEMS (Current or Existing Problems Associated With)

Ears, Nose, Throat (Sinus, Ear Infection, Cough)	Yes	No	Endocrine (Diabetes, Hypothyroid)	Yes	No
Cardiovascular (Heart, Vessels, etc.)	Yes	No	Blood/Lymph (Cholesterol, Anemia)	Yes	No
Respiratory (Asthma, Emphysema, etc.)	Yes	No	Allergic/Immunological (Hay Fever)	Yes	No
Gastrointestinal (Stomach Ulcers, Intestinal Disease, etc.)	Yes	No	Muscles, Bones, Joint (Arthritis, etc)	Yes	No
Skin (Acne, Warts, Skin Cancer, etc)	Yes	No	Neurological (Multiple Sclerosis, etc.)	Yes	No
Psychiatric (Anxiety, Depression, Insomnia)	Yes	No			

FAMILY HISTORY

			Relationship to Patient
Blindness	Yes	No	_____
Glaucoma	Yes	No	_____
Diabetes	Yes	No	_____
Cataracts	Yes	No	_____
Macular Degeneration	Yes	No	_____

PERSONAL HISTORY

Current Occupation: _____ Marital Status: _____ Single _____ Married
_____ Divorced _____ Widow

Have you ever worn contact lenses? _____ Do you currently wear contacts? _____

How long have you worn contacts? _____ Do you currently wear glasses? _____