American Vision Group

PATIENT MEDICAL HISTORY

NAME:_____DATE OF APPOINTMENT:_____
(Please print First, Last)

Were you referred by a medical practitioner? ☐ No ☐ Yes
If Yes, please list the medical practitioner's name _____
Check specialty: ☐ ophthalmology ☐ optometry ☐ general internist ☐ other
Reason for referral: _____

Your answers to the following questions may be very helpful to the doctor.

PLEASE PRINT AND ANSWER ALL QUESTIONS.

1.	Have you had any eye injury or operation?.....	no	yes
	Please list date of operation _____		
2.	Do you now, or have you ever, worn glasses?.....	no	yes
	For Distance?.....	no	yes
	For Reading?.....	no	yes
3.	Do you now, or have ever, worn contact lenses?	no	yes
4.	Have you seen floating dots ("floaters") or flashing lights in either eye in the past?	no	yes
5.	Are there any relatives in your family who are blind or nearly blind in one or both eyes through causes other than by accident?.....	no	yes
6.	Do you have any family history of glaucoma?.....	no	yes
7.	Have you been diagnosed with glaucoma?	no	yes
	If yes, please enter the usual pressure or pressure range for each of your eyes		
	Right eye _____ Left eye _____		
8.	Were your eyes "crossed" as a child?.....	no	yes
9.	Do you have any family history of "crossed" or turned eyes?.....	no	yes
10.	Do you have any family history of cataracts?.....	no	yes
11.	Do you have any family history of macular degeneration?.....	no	yes
12.	Do you have any family history of retinal detachment?.....	no	yes
13.	Do you have any family history of diabetes, high blood pressure or heart disease?.....	no	yes

14. Do you have, or have you had, high blood pressure?..... no yes

15. Do you have kidney trouble?..... no yes

16. Do you have diabetes?..... no yes

17. Do you have heart disease or lung problems?……. no yes

18. Do you have any chronic or serious illness?..... no yes

Please list: _____

_____

19. Please list the approximate dates and types of all previous operations which you have undergone:

DATE	OPERATION
_____	_____
_____	_____
_____	_____

20. Do you have a hearing problem?..... no yes

21. Do you have "sinus" type of pain?..... no yes

22. Do you frequently experience headache?..... no yes

23. Have you ever had a stroke?..... no yes

24. List any prescription and non-prescription medications you are taking or have taken in the past year (including eye drops). Name and purpose of each:

_____

_____

_____

_____

25. Are you allergic to any medicines?..... no yes

Please list: _____

_____

_____,M.D.

DOCTORS SIGNATURE/INITIALS