Aurora VISION CENTER

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Certified Therapeutic Optometrists

American Optometric Association

Medical History Information

Patient Name _____ Birth Date _____

How is your general health? _____

Do you take medications for any of the following systems?

Allergic/Immunologic	yes/no	Eyes	yes/no	Mental	yes/no
Blood/Lymph	yes/no	Gastrointestinal	yes/no	Muscles/Bones	yes/no
Cardiovascular	yes/no	Headaches	yes/no	Nervous	yes/no
Ears/Nose/Throat	yes/no	High Blood Pressure	yes/no	Respiratory	yes/no
Endocrine (glands)	yes/no	Integumentary (skin)	yes/no	Urinary	yes/no

Please explain_____

Diabetes yes/no Type _____ Date of diagnosis _____

Last A1C #: _____ Date_____

Other health problems _____

Current medication(s)_____

_____

Allergies to medication yes/no Which? _____Reactions? _____

Have you had any operations? yes/no

Kind? _____

When? _____

Name of family doctor/primary care physician_____

Personal Eye Information

Do you have any eye conditions or problems? yes/no Kind? _____

Have you had any eye operations? yes/no Type_____

Have you had and eye injury? yes/no Kind _____

Do you have any of the following?

Blurred vision	yes/no	Glaucoma	yes/no
Cataracts	yes/no	Macular degeneration	yes/no
Dry eyes	yes/no	Retinal detachment	yes/no

Do you wear glasses? yes/no

Contact lenses? yes/no Type _____

Are you interested in laser vision correction such as LASIK? yes/no

Additional information _____

Family History (only first degree biological relatives count towards this measure)

Cataracts	yes/no Relation _____	High blood pressure	yes/no Relation _____
Diabetes	yes/no Relation _____	Macular degeneration	yes/no Relation _____
Glaucoma	yes/no Relation _____	Retinal detachment	yes/no Relation _____

Other Family Histories _____