

## Dr. Son Nguyen, OD.

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| PAST/PRESENT MEDICAL HISTORY   Have you been diagnosed with or have bad any of the following? Please check all that apply to you.   High Blood Pressure  | Name:                             |   | Age:        | Date of Birth://                     |
|--|-----------------------------------|---|-------------|--------------------------------------|
| Have you been diagnosed with or have had any of the following? Please check all that apply to you.    High Blood Pressure  | Date of Last Physical://          | Primary Physician's Name:                     |             |                                      |
| High Blood Pressure  |                                   | PAST/PRESENT MEDICA                           | L HIS       | TORY                                 |
| Commonia   | Have you been                     | diagnosed with or have had any of the followi | ing? Please | check all that apply to you.         |
| Heart Condition  | ☐ High Blood Pressure             | ☐ Asthma                                      |             | ☐ Seizures                           |
| Amenia   | High Cholesterol                  | ☐ Pneumonia                                   |             | ☐ Headaches / Migraines              |
| Diabetes   | Heart Condition                   | ☐ Multiple Sclerosis                          |             | □ Alzheimer's Disease                |
| Carrent Medications (including non-prescription drugs):  | Aneurysms                         | ☐ Amenia                                      |             | ☐ Seasonal Allergies                 |
| Stroke   S   | l Diabetes                        | □ Leukemia                                    |             | □ Other                              |
| Steep Apnea  | Thyroid Condition                 | ☐ Cancer                                      |             |                                      |
| Current Medications (including non-prescription drugs):    Do you smoke cigarettes?   Yes   No   Do you drink alcohol?   Yes   No  |                                   | ☐ Stroke                                      |             |                                      |
| Do you smoke cigarettes?   Yes   No   Do you drink alcohol?   Yes   No     No     |                                   |   |             |                                      |
| PAST/PRESENT EYE HISTORY  PAST/PRESENT EYE HISTORY  Date of Last Eye Exam: / Name of Previous Eye Doctor:  Have you been diagnosed with or have had any of the following? Please check all that apply to you.  Glaucoma   Diabetic Retinopathy   Eye Injury    Hemorrhages   Macular Degeneration   Dry Eye    Current Eye Medications (including over-the-counter eye drops):  FAMILY HISTORY  Please check all that apply to anyone in your immediate family.  Glaucoma   Diabetic Retinopathy   Hypertension    Glaucoma   Dry Eye   Doctor:  Hemorrhages   Macular Degeneration   Hypertension    Glaucoma   Diabetic Retinopathy   Hypertension    Glaucoma   Diabetic Retinopathy   Hypertension    Glaucoma   Diabetic Retinopathy   Hypertension    Glaucoma   Diabetic Retinopathy   Hypertension    Glaucoma   High Cholesterol   High Cholesterol    Glaucoma   High Cholesterol   High Cholesterol    Glaucatracts   Stroke  |                                   |   |             |                                      |
| PAST/PRESENT EYE HISTORY  Paste of Last Eye Exam:/ _ Name of Previous Eye Doctor:  Have you been diagnosed with or have had any of the following? Please check all that apply to you.  Glaucoma  |                                   |   |             |                                      |
| PAST/PRESENT EYE HISTORY  Date of Last Eye Exam:/ Name of Previous Eye Doctor:   |                                   | •   |             |                                      |
| Pate of Last Eye Exam:   |                                   |   |             |                                      |
| Have you been diagnosed with or have had any of the following? Please check all that apply to you.  Glaucoma  Glauco |                                   | PAST/PRESENT EYE I                            | HISTO       | ORY                                  |
| Glaucoma   | •                                 |   |             |                                      |
| Retinal Disease  | Have you been                     | diagnosed with or have had any of the followi | ing? Please | check all that apply to you.         |
| Hemorrhages   Macular Degeneration   Macular Degeneration   Macular Degeneration   Dry Eye   Macular Eye Medications (including over-the-counter eye drops):    FAMILY HISTORY   Please check all that apply to anyone in your immediate family.   Hypertension   Please Check all that apply to anyone in your immediate family.   Hypertension   Hemorrhages   Cancer   Other   Hemorrhages   Cancer   Other   High Cholesterol   High Cholesterol   Stroke   Macular Degeneration   Stroke   Macular Degeneration   Stroke   Macular Degeneration   Macular Degenera | l Glaucoma                        | ☐ Diabetic Retinopathy                        |             | □ Eye Injury                         |
| Current Eye Medications (including over-the-counter eye drops):    FAMILY HISTORY  | l Retinal Disease                 | □ Amblyopia                                   |             | □ Other                              |
| FAMILY HISTORY  Please check all that apply to anyone in your immediate family.  Glaucoma  Retinal Disease  Amblyopia  Cancer  Macular Degeneration  Cataracts  Stroke   | l Hemorrhages                     | ☐ Macular Degeneration                        |             |                                      |
| FAMILY HISTORY  Please check all that apply to anyone in your immediate family.  Glaucoma  Diabetic Retinopathy Hypertension Amblyopia Cancer Hemorrhages High Cholesterol Cataracts  Stroke   | l Cataracts                       | □ Dry Eye                                     |             |                                      |
| Please check all that apply to anyone in your immediate family.  Glaucoma  Diabetic Retinopathy  Hypertension  Check  Check  High Cholesterol  Cataracts  Please check all that apply to anyone in your immediate family.  Hypertension  Other  Hypertension   | urrent Eye Medications (including | over-the-counter eye drops):                  |             |                                      |
| Please check all that apply to anyone in your immediate family.  Glaucoma  Diabetic Retinopathy  Hypertension  Check  Check  High Cholesterol  Cataracts  Please check all that apply to anyone in your immediate family.  Hypertension  Other  Hypertension  Hypertension  Hypertension  Hypertension  Hypertension  Hypertension  Hypertension  Hypertension  Stroke   |                                   | FAMILY HISTO                                  | RY          |                                      |
| Retinal Disease  |                                   |   |             | te family.                           |
| Hemorrhages  | ] Glaucoma                        | ***   |             |                                      |
| Hemorrhages  | la Retinal Disease                | □ Amblyopia                                   |             | □ Other                              |
| Cataracts Stroke   | ] Hemorrhages                     | * *   |             |                                      |
| Cataracts  |                                   | ☐ High Cholesterol                            |             |                                      |
| □ Places check this how if there have been no changes to your medical and eve history since your last visit  |                                   |   |             |                                      |
|  | ☐ Please check this b             | ox if there have been no changes to your m    | nedical and | d eve history since your last visit. |
|  |                                   |   |             |                                      |
|  |                                   |   |             |                                      |
|  |                                   |   |             | / /                                  |