Morgan Hill Eyecare Optometry

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PATIENT MEDICAL INFORMATION

Name: _____ **Age:** ____ **Date of Birth:** ____/____/____

Date of Last Physical: ____/____/____ **Primary Physician's Name:** _____

PAST/PRESENT MEDICAL HISTORY

Have you been diagnosed with or have had any of the following? Please check all that apply to you.

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Condition
- ☐ Aneurysms
- ☐ Diabetes
- ☐ Thyroid Condition
- ☐ Sleep Apnea
- ☐ Asthma
- ☐ Pneumonia
- ☐ Multiple Sclerosis
- ☐ Amenia
- ☐ Leukemia
- ☐ Cancer
- ☐ Stroke
- ☐ Seizures
- ☐ Headaches / Migraines
- ☐ Alzheimer's Disease
- ☐ Seasonal Allergies
- ☐ Other
- _____
- _____

Current Medications (including non-prescription drugs)**:** _____

List any allergies to medications: _____

Do you smoke cigarettes? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No

Surgical History (please list any surgical procedure you have had in the past)**:** _____

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
- ☐ Retinal Disease
- ☐ Hemorrhages
- ☐ Cataracts
- ☐ Diabetic Retinopathy
- ☐ Amblyopia
- ☐ Macular Degeneration
- ☐ Dry Eye
- ☐ Eye Injury
- ☐ Other
- _____
- _____

Current Eye Medications (including over-the-counter eye drops)**:** _____

FAMILY HISTORY

Please check all that apply to anyone in your immediate family.

- ☐ Glaucoma
- ☐ Retinal Disease
- ☐ Hemorrhages
- ☐ Macular Degeneration
- ☐ Cataracts
- ☐ Diabetic Retinopathy
- ☐ Amblyopia
- ☐ Cancer
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Hypertension
- ☐ Other
- _____
- _____
- _____

☐ **Please check this box if there have been no changes to your medical and eye history since your last visit.**

_____ ____/____/____

Patient's Signature (Guardian's Signature if under 18) **Date**