UNIVERSITY of HOUSTON

COLLEGE of OPTOMETRY

Cedar Springs Eye Clinic

MEDICAL HISTORY

NAME: _____ **BIRTH DATE:** _____

GENERAL HISTORY

DATE OF LAST EYE EXAM: _____ **EYE DOCTOR:** _____

WEAR GLASSES? ☐YES ☐NO **WEAR THEM:** ☐DISTANCE ☐NEAR READING ☐ALL THE TIME

WEAR CONTACT LENSES? ☐YES ☐NO **TYPE OF LENSES:** _____ **SOLUTIONS:** _____

DO YOU SLEEP IN YOUR LENSES? ☐YES ☐NO **HOW OFTEN REPLACED?** _____WEEKS

EYE AND MEDICAL HISTORY

WHEN WAS YOUR LAST PHYSICAL: _____ **PCP DOCTOR?** _____

LIST PAST EYE INJURIES, SURGERIES: _____

_____

LIST CURRENT EYE MEDICATIONS YOU USE: _____

WHAT IS YOUR GENERAL HEALTH STATUS? ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

LIST ALL OTHER MEDICATIONS (PRESCRIPTION AND OVER THE COUNTER): _____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? (LIST): _____

CIRCLE THE APPROPRIATE BOX AND LIST THE FAMILY MEMBER WHO HAS/HAD THE FOLLOWING:

	SELF	FAMILY	FAMILY MEMBER
PREGNANT	☐YES /☐NO		
BLINDNESS	☐YES /☐NO	☐YES /☐NO	
CATARACT	☐YES /☐NO	☐YES /☐NO	
GLAUCOMA	☐YES /☐NO	☐YES /☐NO	
MACULAR DEGENERATON	☐YES /☐NO	☐YES /☐NO	
DIABETES	☐YES /☐NO	☐YES /☐NO	
HIGH BLOOD PRESSURE	☐YES /☐NO	☐YES /☐NO	
HEART DISEASE	☐YES /☐NO	☐YES /☐NO	
THYROID DISEASE	☐YES /☐NO	☐YES /☐NO	
ARTHRITIS	☐YES /☐NO	☐YES /☐NO	
STROKE	☐YES /☐NO	☐YES /☐NO	
OTHER (LIST)			

SOCIAL HISTORY

SPECIAL VISION NEEDS: _____

DO YOU USE TOBACCO PRODUCTS? ☐YES☐NO TYPE, HOW MUCH? _____

DO YOU DRINK ALCOHOL? ☐YES☐NO HOW MUCH? _____

DO YOU USE ILLEGAL DRUGS? ☐YES☐NO TYPE, HOW MUCH? _____

ARE YOU EMPLOYED? ☐RETIRED ☐YES☐NO TYPE OF WORK: _____