NIPOMO OPTOMETRY
MEMBER VISION SOURCE NETWORK

Patient Medical History Form

Please complete the following form as thoroughly as possible. The information in this confidential case history form is critical to the evaluation of your vision and health.

Family Medical / Eye History

Do you have a family medical history of any of the following?

(Please specify who):

Blindness ☐_____

Cataracts ☐_____

Corneal Problems ☐_____

Diabetes ☐_____

Glaucoma ☐_____

Heart Disease ☐_____

Lazy Eye ☐_____

Macular Degeneration ☐_____

Retinal Problems ☐_____

Lifestyle Questions

Do you… (Check all that apply):

☐…use digital devices on a regular basis? If yes, how many hours per day? _____hrs/day
☐…think you might benefit from thinner, lighter lenses?
☐…prefer NOT to wear glasses at times?
☐…spend time outdoors? How often? ____hrs/week
☐…participate in vision-related sports or other activities? If yes, please specify

_____

_____

_____

Patient Eye History

Date of Last Eye Exam: _____

By Whom? _____

Have you had any eye-related surgeries of any kind?
☐Yes ☐No

Have you ever experienced, been diagnosed or treated for any of the following?

☐Blurry Vision
☐Burning
☐Cataracts
☐Corneal Abrasions
☐Crossed eye/Eye turn
☐Double Vision
☐Eye Infections
☐Eye Injury
☐Flash of light
☐Floaters/Spots
☐Glaucoma
☐Grittiness
☐Headaches
☐Iritis/Uveitis
☐Itchiness
☐Lazy Eye
☐Macular Degeneration
☐Occasional dryness
☐Retinal Detachment
☐Sunlight Sensitivity
☐Tearing
☐Trouble seeing at night
☐Uncomfortable glasses
☐Other eye disorders: _____

Continued on next page…

Patient Medical History
Form, Continued

Patient Medical History

Name of Primary Care Physician: _____

_____

Address: _____

Phone: _____

Date of Last Physical Check-Up: _____

Height:_____Weight:_____

Current Medications (Rx or Over-The-Counter)

(List name of medications, including eye drops, vitamins & birth control pills, dosages, and frequency. Please bring a list if possible!):_____

_____

_____

_____

_____

_____

Allergies to medications? ☐Yes ☐No

If so, what medications? _____

_____

_____

Do you use cigarettes/tobacco, alcohol, or other substances?

☐Yes ☐No

If so, how often?

_____

_____

Patient Medical History, Continued

Have you ever been *diagnosed* or *treated* for the following health problems?

	Yes	No
Allergies	☐	☐
Arthritis	☐	☐
Blood/Lymph	☐	☐
Bronchitis	☐	☐
Cancer	☐	☐
Cholesterol	☐	☐
Diabetes	☐	☐
Digestive	☐	☐
Ears/Nose/Throat	☐	☐
Endocrine	☐	☐
Eczema/Rashes	☐	☐
Fatigue	☐	☐
Fevers	☐	☐
Genitourinary	☐	☐
High Blood Pressure	☐	☐
Integumentary (Skin)	☐	☐
Kidney	☐	☐
Muscle/Bone	☐	☐
Neurological	☐	☐
Psychological	☐	☐
Respiratory	☐	☐
Sinus	☐	☐
Throat Infections	☐	☐
Thyroid	☐	☐
Unusual weight losses/gains	☐	☐