Patient Medical History

VANCE THOMPSON VISION

Patient Name _____ Date of Birth _____

Ht _____ Wt _____

Please list any medications or eye drops you are taking (or have us make a copy of your medications list). _____

_____

_____

Family Doctor _____

Current Eye Doctor _____

Preferred Pharmacy _____

Please list any known medical allergies _____

_____

☐ No ☐ Yes Have you received an influenza vaccine?

☐ No ☐ Yes Have you received a pneumococcal vaccine?

☐ No ☐ Yes Do you rub your eyes?

Are you currently receiving treatment or have you previously been treated for any of the following conditions? If so, please check the box and explain in the right column.

☐ **Fever / Weight Loss** (Other)	
Eyes: ☐ Glaucoma ☐ Cataract ☐ Lazy Eye ☐ Retina Problems ☐ Laser Vision Correction ☐ Other - Please Specify	

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Current treatment and/or conditions, continued.

Cardiovascular: ☐ Heart Problems ☐ Chest Pain ☐ Irregular Heart Beat ☐ High Blood Pressure ☐ High Cholesterol ☐ Other	
Respiratory: ☐ Asthma ☐ Shortness of Breath ☐ Wheezing ☐ Coughing ☐ Other - Please Specify	
Gastrointestinal: ☐ Heartburn ☐ Abdominal Pain ☐ Diarrhea ☐ Vomiting ☐ Other - Please Specify	
Integumentary: ☐ Skin Rashes ☐ Excessive Dryness ☐ MRSA ☐ Other	
Musculoskeletal: ☐ Muscle Aches ☐ Joint Pain ☐ Swollen Joints ☐ Other	
Neurological: ☐ Numbness ☐ Weakness ☐ Headaches ☐ Paralysis ☐ Other	
Hematological / Lymphatic: ☐ Blood Disorders ☐ Leukemia ☐ Other	

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Current treatment and/or conditions, continued:

Allergic / Immunological: ☐ Hay Fever ☐ Allergies ☐ Other - Please Specify	
Endocrine: ☐ Thyroid Problems ☐ Diabetes ☐ Other	
Psychiatric: ☐ Depression ☐ Anxiety ☐ Other - Please Specify	

Family History:

Do any medical or eye diseases run in your family? If YES, please check and note relationship of person to you.

☐ Glaucoma ☐ Macular Degeneration ☐ Diabetes ☐ Cataracts

☐ High Blood Pressure

☐ Other - Please Specify: _____

Relation:_____

Social History:

Do you smoke? ☐ No ☐ Yes - How much_____

Do you drink? ☐ No ☐ Yes - How much _____

Do you take drugs? ☐ No ☐ Yes - How much _____

Occupation _____

Patient's Signature_____ Date_____