INSIGHT
COMPLETE EYE CARE

MEDICAL HISTORY

Print Name: _____ Primary Care Physician: _____

Do you have allergies to any medications? Yes No If so, please list: _____

_____

List all major injuries, surgeries, and/or hospitalizations you have had: _____

_____

Height: _____ Weight: _____

FAMILY MEDICAL HISTORY

Please list any medical diseases that run in your immediate family: _____

OCULAR DISEASE

Does anyone in your immediate family have: Glaucoma Macular Degeneration Other: _____

SOCIAL HISTORY

Do you use tobacco products? Yes No If yes, type/amount/how long? _____

Do you drink alcohol? Yes No If yes, type/amount/how long? _____

Do you use illegal drugs? Yes No If yes, type/amount/how long? _____

Have you been exposed to or infected with: HIV Yes / No Hepatitis Yes / No

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas? Please check yes or no

SYSTEM	YES	NO	MEDICATION
Integumentary			
Skin Disease/Skin Cancer	☐	☐	_____
Neurological			
Headaches	☐	☐	_____
Migraines	☐	☐	_____
Seizures	☐	☐	_____
Numbness, Tingling	☐	☐	_____
Paralysis	☐	☐	_____
Endocrine			
Thyroid Problems	☐	☐	_____
Diabetes	☐	☐	_____
Musculoskeletal			
Arthritis	☐	☐	_____
Lupus	☐	☐	_____
Cardiovascular			
Hypertension	☐	☐	_____
Chest Pain	☐	☐	_____
Heart Attack	☐	☐	_____
Heart Failure	☐	☐	_____
Elevated Cholesterol	☐	☐	_____
Palpitation	☐	☐	_____
Genitourinary			
Sexually Transmitted Disease	☐	☐	_____
Psychiatric			
Depression	☐	☐	_____
Anxiety	☐	☐	_____
Allergic/Immunologic			
Seasonal	☐	☐	_____
Immune Problems	☐	☐	_____
Hay Fever	☐	☐	_____

OCULAR	Yes	No	DATE
Lasik	☐	☐	_____
PRK	☐	☐	_____
Radial Keratotomy (RK)	☐	☐	_____
Corneal Transplant	☐	☐	_____
Crosslinking	☐	☐	_____
Intacs	☐	☐	_____
Cataract Surgery	☐	☐	_____
Strabismus Surgery	☐	☐	_____
Eye Pain	☐	☐	_____
Cataract	☐	☐	_____
Macular Degeneration	☐	☐	_____
Glaucoma	☐	☐	_____
Dry Eyes	☐	☐	_____
Floaters	☐	☐	_____
Retinal Detachment	☐	☐	_____
Keratoconus	☐	☐	_____

Other: _____

_____

_____

Do you currently wear contact lenses? Y / N

If "yes" what kind? _____

Are you wearing now? Y / N

SIGNATURE: _____ **PRINT NAME:** _____ **DATE:** _____