HEARNE VISION CARE MEDICAL HISTORY

Name: _____ Date: _____

Family Physician: _____

General History

Do you have a history of or are currently under treatment for (please circle):

High Blood Pressure	Yes	No	Cancer	Yes	No
Heart Disease	Yes	No	Arthritis	Yes	No
Diabetes	Yes	No	Lupus	Yes	No
Emphysema	Yes	No	Rosacea	Yes	No
Asthma	Yes	No	Thyroid (Low or High)	Yes	No
Stroke	Yes	No	Hepatitis	Yes	No
Seizures	Yes	No	Headache/Migraine	Yes	No

Do you smoke? None <1 pack/day 1-2 packs/day Former smoker

Do you drink alcohol? None Socially 1-2 drinks/day >2 drinks per day

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

Other (please list): _____

Please list all medications you are currently taking: _____

_____

_____

Are you allergic to any medications (please circle): Yes No

Please list all medications you are allergic to and include you **reaction** to each:

_____

Eye Health

Have you ever been treated for or are currently experiencing any of the following (please circle):

Cataracts	Yes	No	Macular Degeneration	Yes	No
Eye Injuries	Yes	No	Retinal Detachment	Yes	No
Eye Surgery	Yes	No	Lazy Eye (Amblyopia)	Yes	No
Glaucoma	Yes	No	Other: _____		

Family History

Please list family members (parents, grandparents, sisters, brothers) who have or have had any of the following disorders:

Diabetes: _____ Macular Degenerations: _____

Cancer: _____ Glaucoma: _____

Heart Disease: _____ Blindness: _____

High Blood Pressure: _____

Other diseases that run in your family: _____