Chan Family Optometry Medical Health History

Last Name:		**First Name:**	
Date of Birth (Month/Day/Year):	**Primary Care Physician:**		**Social Security Number:**
Address:			**Mobile Number:**
City:	**State:**	**Zip Code:**	**Home Phone Number:**

Do you wear Glasses? **Yes/No**	**Do you wear Contact Lenses?** **Yes/No**	**Location of Last Eye Exam:**	**Date of Last Eye Exam:**

Medical Information

If you have any of the following conditions, please check them off:

High Blood Pressure		Eczema		Diabetes	
Heart Disease		Rosacea		Thyroid Dysfunction	
Stroke		Arthritis		Multiple Sclerosis	
Anemia		Muscular Dystrophy		Epilepsy	
Leukemia		Asthma		Emphysema	
Are you pregnant?		Are you nursing?		Other:	

Drug Allergies? Yes/No

If yes, please list the Medications:

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Personal Eye History:

Do you have or have you had any of the following eye conditions?

Amblyopia (lazy eye)		Glaucoma		Strabismus (eye turn)	
Cataracts		Macular Degeneration		Eye surgery/injury	
Color blindness		Retinal detachment		Other:	

Do you have any of the following eye symptoms?

Double Vision		Flashes		Floaters	
Loss of vision		Dryness		Glare	
Redness		Eye pain/soreness		Foreign body sensations	
Itching		Headaches		Other:	

Family Eye History:

Does anyone in your immediate family have:

Amblyopia (lazy eye)		Cataracts		Glaucoma	
Macular Degeneration		Strabismus (eye turn)		Other:	

Social History:

Occupation:	Work Number:
Do you drink alcohol? Yes No	Do you smoke: Yes No
If yes, how often: Occasional 1 Per Day 2-3 Per Day 4+ Per Day	Past smoker? Yes No

Emergency Contact:

Name:	Phone Number:
Relationship:	Can we discuss any medical information with this person? (i.e. schedule appointments, discuss info with doctors, etc.) Yes No

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Medications:

I am not currently taking any medications on a regular basis: Yes/No
I am on a medication regimen: Yes/No

If yes, please fill out the chart below to the best of your ability:

Medication Name	Dose	Frequency (I.e. once a day, twice a day, etc.)	Reason for Medication

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