Chan Family Optometry
MEDICAL HEALTH HISTORY

Last Name_____ First Name_____

Date of last eye exam_____

Reason for today's visit_____

Do you wear glasses? Yes No Do you wear contact lenses? Yes No

Medical Information

Please indicate if you have any of the following conditions:

____High blood pressure ____Eczema ____Diabetes
____Heart disease ____Rosacea ____Thyroid dysfunction
____Stroke ____Arthritis ____Multiple sclerosis
____Anemia ____Muscular dystrophy ____Epilepsy
____Leukemia ____ Asthma ____Emphysema
____Other_____

Are you pregnant? Yes No Are you nursing? Yes No

Drug allergies? Yes No If yes, list medication(s):_____

Primary Care Physician_____ Phone number_____

Date of last physical exam?_____

Personal Eye History

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

____Amblyopia (lazy eye) ____Glaucoma ____Strabismus (eye turn)
____Cataract ____Macular degeneration ____Eye surgery/injury_____
____Color blindness ____Retinal detachment ____Other_____

Do you have or have you had any of the following symptoms?

____Double vision ____ Flashes and/or floaters ____Loss of vision
____Dryness ____ Glare ____Redness
____Eye pain/soreness ____ Headaches ____Other_____
____Foreign body sensation ____Itching

Family Eye History

Does anyone in your immediate family have:

____Amblyopia (lazy eye) ____Cataracts ____Glaucoma ____Macular degeneration

____Other_____

Social History

Occupation_____

Do you drink alcohol? Yes No Unknown If yes, how often? Occasional 1 per day 2-3 per day 4+ per day

Do you smoke? Yes No Unknown Past smoker? Yes No

OVER →

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PATIENT MEDICATION LIST

MEDICATIONS:

____ I am not currently taking any medications on a regular basis.

____ I am on a medication regimen. (Please complete the following medication list.)

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