Eye Health and Medical History

Azle Vision Source

Patient Name: _____ Date of Birth: _____ Date: _____

Referred By: _____

Please check any medical conditions, ocular health conditions, and vision complaints.

Yes No

- ☐ ☐ Ears/Nose/Throat/Mouth Disease
- ☐ ☐ Heart Conditions
- ☐ ☐ **High Blood Pressure**
- ☐ ☐ Blood Disorders
- ☐ ☐ **High Cholesterol**
- ☐ ☐ Urinary or Kidney Disease
- ☐ ☐ Muscle or Joint Conditions
- ☐ ☐ Skin Conditions
- ☐ ☐ Stroke/Neurological Disease
- ☐ ☐ Migraine Syndrome
- ☐ ☐ Mental Health Conditions
- ☐ ☐ Thyroid Imbalance/Disease
- ☐ ☐ Seasonal Allergies
- ☐ ☐ Immune system conditions
- ☐ ☐ Asthma or Lung condition
- ☐ ☐ Stomach/Intestinal Conditions
- ☐ ☐ **Diabetes**
- ☐ ☐ Other _____

Yes No

- ☐ ☐ Blurred Vision-near
- ☐ ☐ Blurred Vision-far
- ☐ ☐ Headaches
- ☐ ☐ Double/Distorted Vision
- ☐ ☐ Fluctuating Vision
- ☐ ☐ Light Sensitivity/Glare
- ☐ ☐ Flasher/Floaters
- ☐ ☐ Dry Eyes
- ☐ ☐ Watery/Burning Eyes
- ☐ ☐ Redness/Itchy Feeling
- ☐ ☐ Loss of Vision-Central
- ☐ ☐ Loss of Vision-Side
- ☐ ☐ Eye Strain
- ☐ ☐ Skips, Re-Reads, or Loses Place while Reading
- ☐ ☐ Amblyopia (Lazy eye)
- ☐ ☐ Other_____

Indicate if YOU, your PARENTS, or FAMILY has had the following conditions and briefly describe.

- ☐ ☐ Glaucoma _____
- ☐ ☐ Macular Degeneration _____
- ☐ ☐ Eye Surgery _____
- ☐ ☐ Other Eye Disease _____

Do use tobacco products? Yes No

Do you drink alcohol? Yes No

Height:_____ Weight:_____ Most recent blood pressure: _____

Medications: Please list all medications you currently take, including any over the counter meds.

_____
_____
_____
_____
_____
_____
_____
_____

Medication Allergies: Please list all medications that you have allergies to.

_____

Who is your Primary Care Physician? Please include clinic name, location and phone number._____