

# Eye Health and Medical History

## Azle Vision Source

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_ Referred By: \_\_\_\_\_

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

Yes No

- Diabetes**
- 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
- Other \_\_\_\_\_

Yes No

- Need an RX for contacts?**
- 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.

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

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