# Wentz Eye Care Medical History Form

**Patient Name:** _____ **Date:** ____ / ____ / _____

**Last Eye Doctor:** _____ **Last Eye Exam:** _____ / _____
month year

**Current Medical Doctor:** _____ **Last Medical Exam:** _____ / _____
month year

**What is your reason for seeking Vision Care at this time?** _____

_____

**Medical History**

**Do you consider your health:** ☐ Good ☐ Fair ☐ Poor **Are you Pregnant?** ☐ Yes ☐ No

**Race:** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race

**Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

**Preferred Language:** ☐ English ☐ Spanish Other:_____

**Height:** _____feet ____inches **Weight:** _____pounds

**Are you currently taking any medications or drugs?** ☐ Yes ☐ No **If yes, what drugs are you taking?**

_____

_____

**Are you allergic to any medications?** ☐ Yes ☐ No **If yes, which drugs?**

| Drug | Reaction | Severity |
|---|---|---|
| _____ | _____ | ☐ Low ☐ Medium ☐ High |
| _____ | _____ | ☐ Low ☐ Medium ☐ High |
| _____ | _____ | ☐ Low ☐ Medium ☐ High |

**List all major injuries, surgeries, and/or hospitalizations you have had:** _____

_____

_____

**What is your current form of vision correction:** ☐ Glasses ☐ Contacts ☐ Glasses & Contacts ☐ None

**Have you ever worn contact lenses?** ☐ Yes ☐ No

**If you wear contacts, what type of contacts do you wear?** ☐ Rigid ☐ Soft ☐ Extended Wear

**Do you wear prescription sunglasses?** ☐ Yes ☐ No

**Do you wear glasses for computer work?** ☐ Yes ☐ No

**Social History**

**Do you drive?** ☐ Yes ☐ No **If yes, do you have visual difficulty while driving?** ☐ Yes ☐ No

**If yes, please describe:** _____

**If you are over 13, do you smoke?** ☐ Never ☐ Former ☐ Some Day ☐ Every Day

**If a smoker, number of cigarettes smoked per day:** ____

**Do you drink alcohol?** ☐ Yes ☐ No **If yes, type/amount/how long:**_____

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

**Have you ever been exposed or infected with:**

☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ No, I have not.

***(Please Complete the Back Side Also)***

## Family History

**Have any of your parents, siblings, or children had any of the following conditions?**

| Ocular Disease / Condition | Yes | No | Relationship to You |
|---|---|---|---|
| Blindness | ☐ | ☐ | ☐Mother ☐Father ☐Sister ☐Brother ☐Daughter ☐Son |
| Cataract | ☐ | ☐ | ☐Mother ☐Father ☐Sister ☐Brother ☐Daughter ☐Son |
| Glaucoma | ☐ | ☐ | ☐Mother ☐Father ☐Sister ☐Brother ☐Daughter ☐Son |
| Macular Degeneration | ☐ | ☐ | ☐Mother ☐Father ☐Sister ☐Brother ☐Daughter ☐Son |
| Retinal Detachment/Disease | ☐ | ☐ | ☐Mother ☐Father ☐Sister ☐Brother ☐Daughter ☐Son |

| Systemic Disease / Condition | Yes | No | Relationship to You |
|---|---|---|---|
| Arthritis | ☐ | ☐ | ☐Mother ☐Father ☐Sister ☐Brother ☐Daughter ☐Son |
| Asthma | ☐ | ☐ | ☐Mother ☐Father ☐Sister ☐Brother ☐Daughter ☐Son |
| Cancer | ☐ | ☐ | ☐Mother ☐Father ☐Sister ☐Brother ☐Daughter ☐Son |
| Diabetes | ☐ | ☐ | ☐Mother ☐Father ☐Sister ☐Brother ☐Daughter ☐Son |
| Heart Disease | ☐ | ☐ | ☐Mother ☐Father ☐Sister ☐Brother ☐Daughter ☐Son |
| High Blood Pressure | ☐ | ☐ | ☐Mother ☐Father ☐Sister ☐Brother ☐Daughter ☐Son |
| Kidney Disease | ☐ | ☐ | ☐Mother ☐Father ☐Sister ☐Brother ☐Daughter ☐Son |
| Thyroid Disease | ☐ | ☐ | ☐Mother ☐Father ☐Sister ☐Brother ☐Daughter ☐Son |
| Other:_____ | | | ☐Mother ☐Father ☐Sister ☐Brother ☐Daughter ☐Son |

## Review of Systems

**Do you currently, or have you ever had any problems in the following areas:**

| System | Yes | No | Not Sure |
|---|---|---|---|
| **Cancer** | ☐ | ☐ | ☐ |
| **Constitutional** | | | |
| Fever/Weight Loss/Gain | ☐ | ☐ | ☐ |
| **Neurological** | | | |
| Headaches | ☐ | ☐ | ☐ |
| Migraines | ☐ | ☐ | ☐ |
| Seizures | ☐ | ☐ | ☐ |
| **Eyes** | | | |
| Loss of Vision | ☐ | ☐ | ☐ |
| Blurred Vision | ☐ | ☐ | ☐ |
| Distorted Vision/Halos | ☐ | ☐ | ☐ |
| Loss of Side Vision | ☐ | ☐ | ☐ |
| Double Vision | ☐ | ☐ | ☐ |
| Dryness | ☐ | ☐ | ☐ |
| Mucous Discharge | ☐ | ☐ | ☐ |
| Redness | ☐ | ☐ | ☐ |
| Sandy or Gritty Feeling | ☐ | ☐ | ☐ |
| Itching | ☐ | ☐ | ☐ |
| Burning | ☐ | ☐ | ☐ |
| Foreign Body Sensation | ☐ | ☐ | ☐ |
| Excess Tearing/Watering | ☐ | ☐ | ☐ |
| Glare/Light Sensitivity | ☐ | ☐ | ☐ |
| Eye Pain or Soreness | ☐ | ☐ | ☐ |
| Chronic Infection of Eye or Lid | ☐ | ☐ | ☐ |
| Sty or Chalazion | ☐ | ☐ | ☐ |
| Flashes/Floaters in Vision | ☐ | ☐ | ☐ |
| Tired Eyes | ☐ | ☐ | ☐ |
| **Endocrine** | | | |
| Thyroid/Other Glands | ☐ | ☐ | ☐ |
| **Skin** (Integumentary) | ☐ | ☐ | ☐ |
| **Allergic/Immunologic** | ☐ | ☐ | ☐ |

| System | Yes | No | Not Sure |
|---|---|---|---|
| **Psychiatric** | | | |
| Depression | ☐ | ☐ | ☐ |
| **Ears, Nose, Mouth, Throat** | | | |
| Allergies/Hay Fever | ☐ | ☐ | ☐ |
| Sinus Congestion | ☐ | ☐ | ☐ |
| Chronic Cough | ☐ | ☐ | ☐ |
| Dry Throat/Mouth | ☐ | ☐ | ☐ |
| Ear Ache | ☐ | ☐ | ☐ |
| **Respiratory** | | | |
| Asthma | ☐ | ☐ | ☐ |
| Chronic Bronchitis | ☐ | ☐ | ☐ |
| Emphysema | ☐ | ☐ | ☐ |
| **Vascular/Cardiovascular** | | | |
| Diabetes | ☐ | ☐ | ☐ |
| Duration: _____ Last Hba1c: _____ | | | |
| High Blood Pressure | ☐ | ☐ | ☐ |
| Vascular Disease | ☐ | ☐ | ☐ |
| Brain Injury/Stroke | ☐ | ☐ | ☐ |
| **Gastrointestinal** | | | |
| Diarrhea | ☐ | ☐ | ☐ |
| Constipation | ☐ | ☐ | ☐ |
| Ulcers | ☐ | ☐ | ☐ |
| **Genitourinary** | | | |
| Genitals/Kidney/Bladder | ☐ | ☐ | ☐ |
| **Bones/Joints/Muscles** | | | |
| Rheumatoid Arthritis | ☐ | ☐ | ☐ |
| Muscle Pain | ☐ | ☐ | ☐ |
| Joint Pain | ☐ | ☐ | ☐ |
| **Lymphatic/Hematologic** | | | |
| Anemia | ☐ | ☐ | ☐ |
| Bleeding Problems | ☐ | ☐ | ☐ |

_____ _____ / _____ / _____

Signature Dated