EYES ON LAKE NORMAN
OPTOMETRY

Please complete the following regarding your personal medical history.

Do you have any problems in the following areas?: (Circle any that apply)

Constitution (cancer, developmental disorder, fatigue, etc): (Y/N) _____

Ear/Nose/Throat (hearing loss, sinusitis, laryngitis, etc): (Y/N) _____

Neurological (multiple sclerosis, epilepsy, migraine, etc): (Y/N)_____

Psychiatric (depression, anxiety, ADD/ADHD, etc): (Y/N) _____

Cardiovascular (hypertension, heart disease/failure, etc): (Y/N)_____

Respiratory (asthma, bronchitis, COPD, etc): (Y/N) _____

Gastrointestinal (Crohn's, colitis, celiac disease, etc): (Y/N)_____

Genitourinary (kidney disease, prostate disease, etc): (Y/N)_____

Musculoskeletal (arthritis, ankylosing, spondylitis, etc): (Y/N) _____

Integumentary (eczema, psoriasis, rosacea, etc): (Y/N) _____

Endocrine (diabetes, thyroid, dysfunction, etc): (Y/N) _____

Hematologic (high cholesterol, anemia, etc): (Y/N) _____

Allergic/Immune (environmental allergies, RA, SLE, etc): (Y/N) _____

Are you pregnant or nursing? (Yes/NO)

ALLERGIES TO MEDICATIONS: (Yes/No): Please List: _____

CURRENT MEDICATIONS:_____

_____

Please include any prescription and over the counter medications and vitamins.

Who is your primary care doctor? _____

Primary care doctor phone number? (If applicable) _____

When was your last eye exam? _____

Diabetic Patients ONLY:

Last A1C:_____ Last fasting blood sugar:_____ Diabetic diagnosis year: _____