Summit Eye Care
OF WISCONSIN

Optometry and Ophthalmology Patient Medical History Form

Patient Name: ____________________
Exam Date: ____________________
MRN: ____________________

Personal Ocular History

Last eye exam date: ____________________

Do you wear glasses?
Yes ◯ No ◯ If yes, how old are they? ____________________

Do you wear contact lenses?
Yes ◯ No ◯ If yes, what brand are they? ____________________
How old is your current pair? ____________________

How many years have you worn contact lenses? ____________________

Do you have any of the following vision concerns?

- ☐ Blurry Vision
- ☐ Eyestrain
- ☐ Severe Sensitivity to Light
- ☐ Frontal Headache
- ☐ Poor Night Vision
- ☐ Glare
- ☐ Double Vision
- ☐ Distorted Vision
- ☐ Fluctuating Vision

Please list any additional vision concerns: ____________________

Do you have any of the following eye health concerns?

- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Tearing/Watering
- ☐ Discharge
- ☐ Dryness
- ☐ Eye Pain
- ☐ Eye Soreness
- ☐ Flashes and/or Floaters

Please list any additional eye health concerns: ____________________

Have you ever been diagnosed with any of the following ocular conditions?

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Diabetic Retinopathy
- ☐ Keratoconus
- ☐ Lazy Eye
- ☐ Dry Eye
- ☐ Eye Infection/Inflammation
- ☐ Contact Lens Overwear
- ☐ Retinal Condition
- ☐ Eye Trauma/Injury

Please list any additional diagnosed ocular conditions: ____________________

Have you ever had any ocular surgeries?
Yes ◯ No ◯ If yes, please list: ____________________

Social History

Occupation: ____________________

Hobbies: ____________________

Approximately how many hours do you spend on a computer daily? ____________________

Review of Systems

Please mark beside any condition you currently have.

Constitutional
- □ Developmental Disabilities
- □ Cancer
  Type: ___________________
- □ Unintentional Weight Loss
- □ Pregnant

ENT
- □ Hearing Loss
- □ Sinusitis
- □ Dry Mouth
- □ Laryngitis

Neurological
- □ Multiple Sclerosis
- □ Epilepsy
- □ Cerebral Palsy
- □ Tumor
- □ Stroke/CVA
- □ Migraine

Psychological
- □ Depression
- □ Attention Deficit
- □ Anxiety Disorder
- □ Bipolar Disorder

Cardiovascular
- □ Hypertension
- □ Stroke/CVA
- □ Heart Disease
- □ Vascular Disease
- □ Congestive Heart Failure

Respiratory
- □ Asthma
- □ Bronchitis
- □ Emphysema
- □ Chronic Obstruction
- □ Sleep Apnea

Gastrointestinal
- □ Crohn’s
- □ Colitis
- □ Ulcer
- □ Acid Reflux
- □ Celiac Disease

Genitourinary
- □ Kidney Disease
- □ Prostate Disease/Cancer

Musculoskeletal
- □ Arthritis
- □ Osteoarthritis
- □ Fibromyalgia
- □ Muscular Dystrophy
- □ Ankylosing Spondylitis
- □ Osteoporosis
- □ Gout

Dermatological
- □ Eczema
- □ Rosacea
- □ Psoriasis
- □ Herpes Simplex/Cold Sores
- □ Herpes Zoster/Shingles

Endocrine
- □ Type 2 Diabetes Mellitus
- □ Type 1 Diabetes Mellitus
- □ Thyroid Dysfunction
- □ Hormonal Dysfunction

Hematologic/Lymphatic
- □ Anemia
- □ Large-Volume Blood Loss
- □ Ulcer
- □ High Cholesterol

Allergic/Immune
- □ Environmental Allergies
- □ Rheumatoid Arthritis
- □ Lupus
- □ Sjogren’s Syndrome

Current Prescription and Non-Prescription Medications (Including Eye Drops):

_______________________ _______________________ _______________________
_______________________ _______________________ _______________________
_______________________ _______________________ _______________________

Allergies to medication: ____

Family History:

Please list parents, grandparents, siblings, or children – living or deceased – with the following conditions:

Glaucoma: ____________________________

Lazy Eye: ____________________________

Macular Degeneration: ____________________________

Color Blindness: ____________________________

Retinal Detachment: ____________________________

Keratoconus: ____________________________

Diabetes: ____________________________

Heart Disease: ____________________________

High Blood Pressure: ____________________________

Kidney Disease: ____________________________

Lupus: ____________________________

Thyroid Disease: ____________________________

Patient Signature: ____