Vitreo-Retinal Associates

Blue Sky VISION Partner

MEDICAL HISTORY FORM

Patient Name		Today's Date / /
Date of Birth / /	Gender M / F	Eye Color

MOST RECENT EYE EXAM		
Exam Date / /	Name of Doctor	Date of Last Glasses / Contacts

PAST OCULAR HISTORY			
	Yes	No	If Yes, Explain
Eye Injuries			
Eye Surgery			
Laser Eye Surgery			
Plastic or Refractive Eye Surgery			
Retinal Problems			
Crossed or Lazy Eyes			
Glaucoma			
Cataracts			

Medication Allergies
Environmental / Seasonal Allergies
Past Major Illnesses or Injuries

Previous Surgeries	Date
	/ /
	/ /
	/ /

CURRENT MEDICATIONS

(including eye medications & drops, over-the-counter medications, vitamins/herbal supplements, inhalers, injections, patches)

Name of Medication	Amount Taken (mg)	How Often

Pharmacy Name & Phone Number

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MEDICAL HISTORY FORM

SOCIAL HISTORY				
	Yes	**No**	**If Yes, How Much**	**If Yes, How Long**
Smoking				
Alcohol				
Recreational / Street Drugs				
Pregnant			**Due Date**	
Hobbies				
Living Arrangement (check one)	○ Alone ○ With Spouse / Significant Other ○ With Family / Friend(s) ○ Assisted Living ○ Nursing Home ○ Other: _____			

CURRENT MEDICAL CONDITIONS			
	Yes	**No**	**If Yes, Explain (how long, complications, etc.)**
Diabetes			
High Blood Pressure			
High Cholesterol			
Thyroid Disorders			
Stroke			
Heart Disease			
Respiratory Problems			
Psychological Disorders			
Headaches / Dizziness			
Fever / Weight Loss			
Muscle / Bone / Joint Problems			
Blood / Bleeding Disorders			
Abdominal Problems			
Genital / Urinary Problems			
Ears / Nose / Throat Problems			
Skin Disorders			
Immunologic Disorders			
Neurological Disorders			
Cancer			
Other			

FAMILY MEDICAL HISTORY			
Retinal Detachment / Tear			
Macular Degeneration			
Diabetic Retinopathy			
Cataracts			
Glaucoma			
Blindness			
Diabetes			
Hypertension			
Heat Disease			
Cancer			