Kish Health System
HAUSER-ROSS OPTICAL

PATIENT MEDICAL HISTORY

Name ______________________________ **Date** __________________
Age ______ **Male / Female**

Knowledge of your current and past medical problems is very helpful to the doctor. Your answers to the following questions will help us give you the best care. Please indicate by a check mark (a) or by filling in the blanks, your answers to the following questions. If you do not know the answer, simply insert a question mark (?). Please print.

What problems(s) are you having with your eyes? ____

____

____

Are you having trouble with any of the following? (check all that apply)

Difficulty Driving

Y	N		Y	N	
❒	❒	at night	❒	❒	parking
❒	❒	glare from headlights	❒	❒	seeing road signs
❒	❒	glare from sunlight	❒	❒	seeing bus signs
❒	❒	driving over curbs	❒	❒	recent accident
❒	❒	judging distance	❒	❒	stopped driving

Other

Y	N		Y	N	
❒	❒	difficulty reading medication bottle labels	❒	❒	recent falls
			❒	❒	faces blurred
❒	❒	difficulty reading fine print	❒	❒	film over eye
			❒	❒	seeing colors
❒	❒	difficulty sewing	❒	❒	seeing golf ball

Do you have glasses? ❒ Y ❒ N
For how long? __________________
How long ago did you see your optometrist? __________________
Do you use eyedrops? What type? ____

Do you have contact lenses? ❒ Y ❒ N
❒ gas permeable ❒ soft ❒ disposable

ADDITIONAL FOR INFANTS & CHILDREN 15 OR YOUNGER:

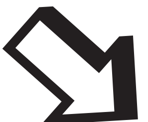
Was infant/child born premature? ❒ Y ❒ N
If so, how early? _________birth weight __________
What was actual due date? ______________________
On oxygen after birth? ❒ Y ❒ N How long? ______
List any developmental delays:
____
Down's Syndrome ❒ Y ❒ N
List any chromosomal or genetic defects:
____
Any other pediatric disorders?
____
Have you noticed any eye deviations?
❒ turning in ❒ turning out
At what age did you first notice this? _____________
Has child been treated by patching in the past? ❒ Y ❒ N
Does child seem to see well and function well at home / school? ❒ Y ❒ N
Comments ____________________________________
____

Have you ever had or still have:

Y	N	
❒	❒	Amblyopia / Lazy Eye
❒	❒	Cataract
❒	❒	Glaucoma
❒	❒	Dry Eye
❒	❒	Keratoconus
❒	❒	Corneal Abrasion
❒	❒	Recurrent Erosion
❒	❒	Herpes Eye Infection
❒	❒	Corneal Infection
❒	❒	Corneal Ulcer
❒	❒	Corneal Scar
❒	❒	Allergic Conjunctivitis

Office Use Only
Reviewed:
__________ __________ __________
__________ __________ __________
__________ __________ __________

2-Sided Form



9/20/05 md

Hauser-Ross Optical

Patient Medical History

3/13/07 md

Please list your **drug allergies** and reactions:

____

____

____

Medications

Please list your current medications and how often you take them (include daily use of aspirin, NSAID, coumadin, Plavix, ginkgo biloba, vitamin E, other anticoagulants, and eyedrops):

____

Have you ever had or still have:

Y	N	
❒	❒	Asthma
❒	❒	Emphysema
❒	❒	Other Lung Problems
❒	❒	High Blood Pressure Diagnosed when? ________
❒	❒	High Cholesterol
❒	❒	Stroke
❒	❒	Heart Attack
❒	❒	Congestive Heart Failure
❒	❒	Rheumatic Fever
❒	❒	Other Circulation Problems
❒	❒	Kidney Infections
❒	❒	Kidney Stones
❒	❒	Kidney Failure
❒	❒	Inability to Urinate
❒	❒	Other Kidney, Bladder, or Prostate Problems
❒	❒	Hepatitis
❒	❒	Cirrhosis
❒	❒	Other Liver Diseases
❒	❒	Ulcers
❒	❒	Diaphragmatic Hernia (Hiatal)
❒	❒	Diverticulitis
❒	❒	Autoimmune/Collagen Vascular Disorder
❒	❒	Cancer Type ______________

Y	N	
❒	❒	Arthritis
❒	❒	Muscular Dystrophy
❒	❒	Other Bone/Muscle Disease
❒	❒	Epilepsy
❒	❒	Polio
❒	❒	Paralysis
❒	❒	Multiple Sclerosis
❒	❒	Parkinson's Disease
❒	❒	Alzheimer's/Dementia
❒	❒	Anemia
❒	❒	Bleeding Disorders
❒	❒	Sugar Diabetes Diagnosed when?_______
❒	❒	Thyroid Disease
❒	❒	Steroid Use (Prednisone)
❒	❒	Scarring or healing abnormalities
❒	❒	Problems with local or general anesthesia
❒	❒	Are you currently trying to become/are pregnant?
❒	❒	Are you taking fertility

Social History

Y	N	
❒	❒	Use Tobacco
❒	❒	Use Alcohol
❒	❒	Use Other Substances

Please list all previous operations (including eye surgery or eye laser surgery). Include complications of anesthesia or surgery and year done.

____

____

____

____

Family History

Have any of your blood relatives had:

Y	N	
❒	❒	Cancer
❒	❒	Diabetes
❒	❒	Heart Problems
❒	❒	Glaucoma

____

____