Northwestern Ophthalmology
Your Vision, Our Mission.

Medical History

Patient Name: _____ **DOB:** _____

Date: _____ **Name of Optometrist:** _____

Name of Medical Doctor: _____

Are you under the care of a physician? ◯ **YES** ◯ **NO**

REVIEW OF SYSTEMS: Do you have (Circle Yes or No):

Fever, Weight Change	◯	◯	Numbness/Tingling	◯ Yes	◯ No
Eye Pain or Decreased Vision	◯	◯	Excessive Thirst	◯ Yes	◯ No
Nausea/Vomiting	◯	◯	Difficulty Fighting Infection	◯ Yes	◯ No
Bladder Frequency	◯	◯	Depression	◯ Yes	◯ No
Difficulty Urinating	◯	◯	Shortness of Breath/Cough	◯ Yes	◯ No
Heart Attack/Chest Pain	◯	◯	Skin Problems	◯ Yes	◯ No
Stomach Pain/Reflux	◯	◯	Back Pain	◯ Yes	◯ No

Additional Symptoms : _____

PAST EYE HISTORY: Do you have (Circle Yes or No):

Glaucoma	◯ Yes	◯ No	Cataract	◯ Yes	◯ No
Macular Degeneration	◯ Yes	◯ No	Diabetes	◯ Yes	◯ No
Retinal Detachment	◯ Yes	◯ No	Lazy Eye	◯ Yes	◯ No
			Other	_____	

PRIOR EYE SURGERIES

_____
_____
_____
_____

CURRENT EYE MEDICATIONS

_____
_____
_____
_____

FAMILY HISTORY (Circle):

☐ Glaucoma ☐ Macular Degeneration
☐ Retinal Detachment ☐ Cataract
☐ Diabetes ☐ Lazy Eye
Other _____

PAST MEDICAL HISTORY: Do you have (Circle Yes or No):

Diabetes	◯ Yes	◯ No	Heart Attack	◯ Yes	◯ No
Hypertension	◯ Yes	◯ No	Asthma	◯ Yes	◯ No
Increased Cholesterol	◯ Yes	◯ No	COPD	◯ Yes	◯ No
Prostate Cancer/Difficulty Urinating	◯ Yes	◯ No	Stroke	◯ Yes	◯ No

Other_____

ADDITIONAL MEDICAL HISTORY (List):

Prior Surgeries	Current Medications		
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DRUG ALLERGIES (i.e. Penicillin, Sulfa, Etc.):

SOCIAL HISTORY:

Tobacco use	◯ Yes	◯ No	packs per day_____		
Alcohol use	◯ Yes	◯ No	drinks per week_____	Other ◯ Yes	◯ No
Drug use	◯ Yes	◯ No			

Occupation:_____

Does your occupation place you at high risk for eye injury? ◯ Yes ◯ No