Eyes in Disguise Optometry
Michelle C Blas, OD

Patient Medical History

Ocular History

Do you wear glasses? ☐ Yes ☐ No If yes, how old is your current pair of glasses? _____

Do you wear contact lenses? ☐ Yes ☐ No If yes what type? ☐ Rigid ☐ Soft ☐ Toric ☐ Multifocal

Contact Lens Brand: _____

Have you had ocular surgery? _____ If yes, Date: _____ Type: _____

What other services would you like to be evaluated for? _____

Are you having any visual difficulties? If yes, please explain: _____

_____

Have you ever been diagnosed with any of the following?

☐ Cataract ☐ Age-related macular degeneration ☐ Glaucoma ☐ Diabetes ☐ Diabetic Retinopathy
☐ Dry Eye ☐ Eye infection ☐ Floaters and/or flashes of light ☐ Eye Inflammation or Allergy
☐ Iritis or Uveitis ☐Retina Defects or degenerations ☐ Crossed Eyes ☐ Lazy Eye/Amblyopia

Are you having any of the following eye concerns?
☐ Redness ☐ Burning ☐ Itching ☐ Tearing ☐ Discharge ☐ Blurred Vision ☐ Eyestrain ☐ Eye Pain ☐ Headache
☐ Overly Sensitive to Lights ☐ Poor Night Vision ☐ Night Glare ☐ Double Vision ☐ Total Loss of Vision ☐ Styes or Chalazion ☐ Mucous Discharge

Medical History

List any medications you are currently taking (include oral contraceptives, aspirin, and over the counter medications):

_____

_____

Are you allergic to any medications? ☐ No ☐ YesIf yes, which ones: _____

Are you currently pregnant or nursing (if applicable)? _____

Review of Systems

Constitution:
- □ Negative
- □ Developmental Disabilities
- □ Cancer
- □ Fatigue Syndrome
- □ Other

ENT:
- □ Negative
- □ Hearing Loss
- □ Sinusitis
- □Dry Mouth
- □ Laryngitis
- □Other

Neuro:
- □ Negative
- □ Multiple Sclerosis
- □ Epilepsy
- □ Cerebral Palsy
- □ Tumor
- □ Stroke/CVA
- □ Migraine
- □ Autism Spectrum Disorder
- □ Other

Psych:
- □ Negative
- □ Depression
- □ Attention Deficit
- □ Anxiety Disorder
- □ Bipolar Disorder
- □ Other

Cardiovascular:
- □ Negative
- □ Hypertension
- □ Stroke/CVA
- □ Heart Disease
- □ Vascular Disease
- □ Congest Heart Failure
- □ Other

Respiratory:
- □ Negative
- □ Cigarette Smoker
- □ Asthma
- □ Emphysema
- □ Chronic Obstruction
- □ Sleep Apnea
- □ Other

GI:
- □ Negative
- □ Crohn's
- □ Colitis
- □ Ulcer
- □ Acid Reflux
- □ Celiac Disease
- □Other

GU:
- □ Negative
- □ Kidney Disease
- □ Prostate Disease/Cancer
- □ STD- herpetic/chlamydia
- □ Benign Prostate Hypertrophy
- □ Pregnant
- □ Nursing
- □ Herpes
- □ Chlamydia
- □ Other

Musc/Skel:
- □ Negative
- □ Osteoarthritis
- □ Arthritis
- □ Fibromyalgia
- □ Muscular Dystrophy
- □ Ankylosing Spondylitis
- □ Osteoporosis
- □ Gout
- □ Other

Integumentary:
- □ Negative
- □ Eczema
- □ Rosacea
- □ Psoriasis
- □ Herpes Simplex/Cold Sores
- □ Herpes Zoster/Shingles
- □ Other

Endocrine:
- □ Negative
- □ Type 2 Diabetes Mellitus
- □ Type 1 Diabetes Mellitus
- □ Thyroid Dysfunction
- □ Hormonal Dysfunction
- □ Other

Hem/Lymph:
- □ Negative
- □ Anemia
- □ Large-volume blood loss
- □ Ulcer
- □ High Cholesterol
- □ Other

Allergy/Imm:
- □ Negative
- □ Drug Allergies
- □ Environmental Allergies
- □ Rheumatoid Arthritis
- □ Lupus
- □ Sjogren's Syndrome
- □ Other

Have you had any major injuries, illnesses, hospitalizations and or surgeries that we should know about? If yes, please explain: _____

Family History

Please note any family history for the following conditions:

Cancer	□ Mother	□ Father	□ Sister	□Brother
Type 1 Diabetes	□ Mother	□ Father	□ Sister	□Brother
Type 2 Diabetes	□ Mother	□ Father	□ Sister	□Brother
Hypertension	□ Mother	□ Father	□ Sister	□Brother
Hyperthyroidism	□ Mother	□ Father	□ Sister	□Brother

Hypothyroidism	□ Mother	□ Father	□ Sister	□Brother
Cataract	□ Mother	□ Father	□ Sister	□Brother
Macular Degeneration	□ Mother	□ Father	□ Sister	□Brother
Glaucoma	□ Mother	□ Father	□ Sister	□Brother

Please describe any other family medical history that may be relevant:

_____

Social History

This information is kept strictly confidential; however, you may discuss this with your doctor directly if you prefer.

Do you currently use tobacco products? □ No □ Yes If yes, type/how long: _____

Do you drink alcohol? □ No □ Yes If yes, type/amount: _____

Signature: _____ Date:_____