Eye Land Optometry
1150 E Artesia Blvd, Long Beach, CA 90805

Medical History

Name: _____ Today's Date: _____

Address: _____ Primary Phone: _____ H W C

City: _____ State: _____ Zip: _____ Email: _____

Guardian (If Applicable): _____ Occupation: _____

Date of Birth: _____ Social Security Number: _____ Last Eye Exam: _____

Name of Medical Doctor: _____ Dr's Phone #: _____

Last Medical Exam: _____

Do you have any allergies to medicaitons? Yes No If yes, explain: _____

_____

List any medications you currently take (including oral contraceptives, aspirin, OTC meds, herbal remedies, etc): _____

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Have you ever been diagnosed with any eye diseases or conditions? Yes No I don't know

Crossed Eye(s) Lazy Eye Drooping Eyelids Bulging Eyes Glaucoma

Retinal Disease Cataracts Eye Infections Other:_____ _____

Are you Pregnant or Nursing? Yes No

Do you wear eyeglasses? Yes No How old are your present pair of lenses? _____

Do you wear contact lenses? Yes No How old are your present pair of lenses? _____

Type of contact lens? Rigid Soft Other Brand of lens? _____ Are you happy with them? Y N

Social History (This information is strictly confidential, however, you may discuss this portion with the doctor if you prefer)

Do you drive? Yes No Do you have visual difficulty when driving? Yes No

Please describe: _____

Do you use tobacco products? Yes No Type/Amount/How long? _____

Do you drink alcohol? Yes No Type/Amount/How long? _____

Do you use illegal drugs? Yes No Type/Amount/How long? _____

Have you ever been exposed to or infected with? : Gonorrhea Hepatitis HIV Syphilis

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Review of Systems: Do you currently or have you ever had any problems in the following areas?:

Eyes			**Constitutional**			**Endocrine**		
Loss of Vision	Y	N	Fever, Weight Loss/Gain	Y	N	Thyroid	Y	N
Blurred Vision	Y	N	**Integumentary (Skin)**	Y	N	Diabetes	Y	N
Distorted Vision / Halos	Y	N	**Neurological**			**Respiratory**		
Double Vision	Y	N	Headaches	Y	N	Asthma	Y	N
Dryness	Y	N	Seizures	Y	N	Chronic Bronchitis	Y	N
Mucous Discharge	Y	N	Migraines	Y	N	Emphysema	Y	N
Redness	Y	N	**Ears, Nose, Mouth, Throat**			**Gastrointestinal**		
Sandy/Gritty Sensation	Y	N	Allergies/Hay Fever	Y	N	Diarrhea	Y	N
Itching	Y	N	Sinus Congestion	Y	N	Constipation	Y	N
Burning	Y	N	Runny Nose	Y	N	**Genitourinary**		
Foreign Body Sensation	Y	N	Post-Nasal Drip	Y	N	Genitals / Kidneys / Bladder	Y	N
Excess Tearing / Watering	Y	N	Chronic Cough	Y	N	**Bones / Joints / Muscles**		
Glare / Light Sensitivity	Y	N	Dry Mouth / Throat	Y	N	Rheumatoid Arthritis	Y	N
Eye Pain or Soreness	Y	N	**Vascular / Cardiovascular**			Muscle /Joint Pain	Y	N
Chronic Infection of Eye or Lid	Y	N	Heart Disease	Y	N	**Lymphatic / Hematologic**		
Sties or Chalazion	Y	N	High Blood Pressure	Y	N	Anemia / Bleeding Problems	Y	N
Flashes / Floaters in Vision	Y	N	Vascular Disease	Y	N	**Allergic / Immunologic**	Y	N
Tired Eyes	Y	N				**Psychiatric**	Y	N

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

_____

_____

Family History: Please note any family history (parents/grandparents/siblings/children; living or deceased

Disease			**Relationship to you**
Blindness	Y	N	
Cataracts	Y	N	
Crossed Eyes	Y	N	
Glaucoma	Y	N	
Macular Degeneration	Y	N	
Retinal Detachment / Disease	Y	N	
Arthritis	Y	N	
Cancer	Y	N	
Diabetes	Y	N	
Heart Disease	Y	N	
High Blood Pressure	Y	N	
Kidney Disease	Y	N	
Lupus	Y	N	
Thyroid Disease	Y	N	