VANCE THOMPSON VISION

PATIENT MEDICAL HISTORY

Patient Name_____

Date of Birth_____ Ht: _____ Wt:_____

Social Security Number_____ Email Address _____

Please list any medications or eye drops you are taking (or have us make a copy of your medications list).

_____

_____

Family Doctor _____Current Eye Doctor _____

Please list any known medical allergies _____

Are you currently receiving treatment or have you previously been treated for any of the following conditions? If so, please circle and explain in the right column.

Fever / Weight Loss (Other)	
Eyes Glaucoma / Cataract / Lazy Eye / Retina problems / Laser Vision Correction / Other - Please Specify	
Cardiovascular Heart problems / Chest pain / Irregular Heart Beat / High Blood Pressure / High Cholesterol / Other	
Respiratory Asthma / Shortness of Breath / Wheezing / Coughing / Other - Please Specify	
Gastrointestinal Heartburn / Abdominal Pain / Diarrhea / Vomiting / Other - Please Specify	
Integumentary Skin Rashes / Excessive Dryness / Other	
Musculoskeletal Muscle Aches / Joint Pain / Swollen Joints / Other	
Neurological Numbness / Weakness / Headaches / Paralysis / Other	
Hematologic / Lymphatic Blood Disorders / Leukemia / Other	
Allergic / Immunologic Hay Fever/ Allergies / Other - Please Specify	
Endocrine Thyroid problems / Diabetes / Other	
Psychiatric Depression / Anxiety / Other - Please Specify	

Family History: Do any medical or eye diseases run in your family? If YES, please circle and note relationship of person to you. Glaucoma / Macular Degeneration / Diabetes / Cataracts / High Blood Pressure
Other - Please Specify_____

_____

Social History:

Do you Smoke? If yes, how much_____ Do you Drink? If yes, how much _____

Do you take Drugs? If yes, how much_____ Occupation _____

Patient's Signature_____ Today's Date_____