peak VISION CLINIC

KEELY HOBAN, OD • DAVID CARKNER, OD • EMILY BEE, OD

Patient Medical History Form

Date of Last Eye Exam:_____ **Name of Doctor / Clinic:** _____
Primary Care Physician / Clinic: _____

Medications - please list current medications; prescription and over-the-counter, and what they are used for:

_____
_____
_____
_____

*Are you currently taking: ☐ Flomax ☐ Coumadin ☐ Aspirin ☐ Plaquenil ☐ Accutane ☐ Digoxin ☐ Levothyroxine ☐ Viagra

Allergies - please list all known allergies to medications, foods, animals, etc.

_____
_____
_____

Eye Health History

Have you ever been diagnosed with any eye conditions or had any injuries to the eye(s)? ☐ Yes ☐ No

If yes, please describe: _____
_____
_____

Have you ever been diagnosed with any eye conditions requiring vision therapy / patching / eye surgery? ☐ Yes ☐ No

If yes, please describe:_____
_____
_____

Have you ever had LASIK, PRK, or Keratotomy? Please list date and facility: _____

Social History

	Yes	No	
Do you wear glasses?	☐	☐	If yes, how old are you current glasses? _____
Do you wear contact lenses?	☐	☐	If yes, what kind? _____ Disposal frequency: ☐daily ☐ biweekly ☐ monthly ☐ other
Do you currently smoke tobacco?	☐	☐	If yes: occasional ☐½ pack/day ☐ 1 pack/day ☐ 2 pack/day ☐ 3+ pack/day
Have you ever been a smoker?	☐	☐	If yes, for how many years? _____
Do you consume alcohol?	☐	☐	
Are you currently pregnant?	☐	☐	If yes, expected due date: _____
Are you currently nursing?	☐	☐	
Are you currently employed?	☐	☐	If yes, occupation? _____
Do you use the computer?	☐	☐	If yes, how many hours per day? _____

Please list any hobbies / sports / extracurricular activities that you have specific visual needs for: _____
_____
_____

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	Yes	No		
Constitutional	☐	☐	Developmental Disabilities	
	☐	☐	Cancer	
	☐	☐	Fatigue Syndrome	
	☐	☐	Other: _____	
	☐		None apply	
Ear/Nose/Throat	☐	☐	Hearing Loss	
	☐	☐	Sinusitis	
	☐	☐	Dry Mouth	
	☐	☐	Laryngitis	
	☐	☐	Other: _____	
	☐		None apply	
Neurological	☐	☐	Multiple Sclerosis	
	☐	☐	Epilepsy	
	☐	☐	Cerebral Palsy	
	☐	☐	Tumor	
	☐	☐	Stroke/CVA	
	☐	☐	Migraine	
	☐	☐	Autism Spectrum Disorder	
	☐	☐	Other: _____	
	☐		None apply	
Psychological	☐	☐	Depression	
	☐	☐	Attention Deficit Disorder	
	☐	☐	Anxiety Disorder	
	☐	☐	Bipolar Disorder	
	☐	☐	Other: _____	
Cardiovascular	☐	☐	Hypertension	
	☐	☐	Stroke/CVA	
	☐	☐	Heart Disease	
	☐	☐	Vascular Disease	
	☐	☐	Congestive Heart Failure	
	☐	☐	Other: _____	
Respiratory	☐	☐	Asthma	
	☐	☐	Emphysema	
	☐	☐	Chronic Obstruction (COPD)	
	☐	☐	Sleep Apnea	
	☐	☐	Other: _____	
Gastrointestinal	☐	☐	Crohn's Disease	
	☐	☐	Ulcerative Colitis	
	☐	☐	Ulcer	
	☐	☐	Acid Reflux	
	☐	☐	Celiac Disease	
	☐	☐	Other: _____	
Allergy/Immun	☐	☐	Drug Allergies	
	☐	☐	Environmental Allergies	
	☐	☐	Rheumatoid Arthritis	
	☐	☐	Lupus	
	☐	☐	Sjogren's Syndrome	
	☐	☐	Other: _____	

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Patient Medical History

	Yes	No	
Hem/Lymph	☐	☐	Anemia
	☐	☐	Large-volume Blood Loss
	☐	☐	High Cholesterol
	☐	☐	Other: _____
Genitourinary	☐	☐	Kidney Disease
	☐	☐	Prostate Disease / Cancer
	☐	☐	STDs - Herpes / Chlamydia
	☐	☐	Benign Prostate Hypertrophy
	☐	☐	Other: _____
Musculoskeletal	☐	☐	Osteoarthritis
	☐	☐	Arthritis
	☐	☐	Fibromyalgia
	☐	☐	Muscular Dystrophy
	☐	☐	Ankylosing Spondylitis
	☐	☐	Osteoporosis
	☐	☐	Gout
	☐	☐	Other: _____
Integumentary	☐	☐	Eczema
	☐	☐	Rosacea
	☐	☐	Psoriasis
	☐	☐	Herpes Simplex / Cold Sores
	☐	☐	Herpes Zoster / Shingles
	☐	☐	Other: _____
Endocrine	☐	☐	Type 2 Diabetes Mellitus
	☐	☐	Type 1 Diabetes Mellitus
	☐	☐	Thyroid Dysfunction
	☐	☐	Hormonal Dysfunction
	☐	☐	Other: _____

Family Health History

Eye Conditions

	Yes	No	Relationship to Patient
Cataracts	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Legal Blindness	☐	☐	_____
Color Blindness	☐	☐	_____
Retinal Detachment	☐	☐	_____
Other Eye Conditions (please specify)			_____

Systemic Conditions

	Yes	No	Relationship to Patient
Diabetes (Type 1 or 2)	☐	☐	_____
High Blood Pressure	☐	☐	_____
Heart Disease	☐	☐	_____
Thyroid Condition(s)	☐	☐	_____
Multiple Sclerosis	☐	☐	_____
Cancers	☐	☐	_____
Stroke	☐	☐	_____
Arthritis	☐	☐	_____