DRS. DRIVER & CLARK, P.A.
HISTORY FORM

Name: _____   **Date:** _____

OCULAR:

If your last eye examination was not with our doctors who was it with and when?_____

Please check any that you use:

☐ Eyeglasses   ☐ Sunglasses   ☐ Contact Lenses   ☐ Readers / Magnifiers

MEDICAL:

PLEASE ATTACH OR COMPLETE THE MEDICATION LIST ON THE REVERSE SIDE

Who is your family doctor & when was your last medical exam? _____

What medications are you allergic to? _____

Please list major surgeries, hospitalizations or severe injuries you have had: _____

_____

_____

SOCIAL:

Do you drive? Yes___ No___   Live alone? Yes___ No ___   Pregnant or Nursing? Yes___ No___   Have indoor pets? Yes___ No___

Please check any that you consume:

☐ Tobacco Products   ☐ Alcohol   ☐ Vitamins / Supplements   ☐ Recreational Drugs

FAMILY HISTORY: *Please check if any apply to your parent, grandparents, siblings, aunt, or uncle:*

☐ Cataracts / Implants   ☐ Glaucoma   ☐ Macular Degeneration
☐ Cancer   ☐ Diabetes   ☐ Heart Disease

REVIEW OF YOUR BODY SYSTEMS (ROS): *Please check any of the following that apply to you.*

EYES:	CONSTITUTIONAL:	GENITOURINARY:	ENDOCRINE:	EAR, NOSE, THROAT:
☐ Loss of Vision	☐ Frequent Fevers	☐ Bladder Condition	☐ Thyroid	☐ Allergies
☐ Blurred Vision	☐ Changes in Weight	☐ Kidney Problems	☐ Para Thyroid	☐ Sinusitis
☐ Sudden Blindness	☐ Overweight	☐ Prostate Issues	☐ NONE	☐ Vertigo
☐ Halos	☐ NONE	☐ NONE		☐ *Hearing Aids*
☐ Blind Spots				☐ NONE
☐ Double Vision				
☐ Light Flashes	GASTROINTESTINAL:	PSYCHIATRIC:	VASCULAR:	IMMUNOLOGIC:
☐ Floaters	☐ Constipation	☐ Depression	☐ Diabetes	☐ HIV
☐ Wavy Lines	☐ Diarrhea	☐ Anxiety	☐ Heart Condition	☐ AIDS
☐ Itchiness	☐ Chron's	☐ Bipolar	☐ Blood Pressure	☐ Hepatitis
☐ Dryness	☐ Reflux / GERD	☐ PTSD	☐ Cholesterol	☐ NONE
☐ Watery	☐ NONE	☐ NONE	☐ NONE	
☐ Styes				
☐ Crossed Eyes				
☐ Lazy Eye	NEUROLOGICAL:	RESPIRATORY:	BLOOD, LYMPHATIC:	BONES, MUSCLES:
☐ Droopy Lid	☐ Migraines	☐ Asthma	☐ Anemia	☐ Arthritis
☐ Glaucoma	☐ Seizures	☐ COPD	☐ Bleeding Disorder	☐ Fibromyalgia
☐ Cataract	☐ Stroke	☐ Oxygen Use	☐ NONE	☐ Muscle Disorder
☐ Lens Implant	☐ MS	☐ NONE		☐ Gout
☐ Retina Condition	☐ Dementia			☐ Back Pain
☐ Eye Injuries	☐ Alzheimer's			☐ *Cane*
☐ NONE	☐ Autism	INTEGUMENTARY:	CANCER: (List)	☐ *Walker*
	☐ Neuropathy	☐ Skin Condition	☐ NONE	☐ *Wheelchair*
	☐ ADD / ADHD	☐ NONE		☐ NONE
	☐ NONE			

(OVER)