Icare Optical

Patient Medical History

EYE HISTORY
Date of Last Exam
Currently Wear Glasses?
Currently Wear Contacts?
Reason for Today's Visit

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Cataracts	Yes	No	Family
Crossed Eye/ Lazy Eye	Yes	No	Family
Glaucoma	Yes	No	Family
LASIK or PRK	Yes	No	Family
Macular Degeneration	Yes	No	Family
Retinal Detachment	Yes	No	Family

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ☐ Blurry Vision
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/ Watering
- ☐ Eye Infection
- ☐ Eye Pain/ Soreness
- ☐ Floaters/ Spots
- ☐ Haloes
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy/ Gritty Feeling

MEDICAL HISTORY			
Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.			
AIDS/ HIV	Yes	No	Family
Allergies	Yes	No	Family
Arthritis	Yes	No	Family
Asthma	Yes	No	Family
Blood/ Lymph Disorder	Yes	No	Family
Cancer	Yes	No	Family
Diabetes	Yes	No	Family
Ears, Nose, Throat Conditions	Yes	No	Family
GI (Stomach) Conditions	Yes	No	Family
Heart Disease	Yes	No	Family
High Cholesterol	Yes	No	Family
Kidney Disease	Yes	No	Family
Lupus	Yes	No	Family
Neurological Conditions	Yes	No	Family
Psychiatric Disorder	Yes	No	Family
Seizures	Yes	No	Family
Skin Conditions	Yes	No	Family
Stroke	Yes	No	Family
Thyroid Dysfunction	Yes	No	Family

Is your blood pressure	Low	Normal	High
Medication Drug Allergies			
1.			
2.			
3.			
Height			
Weight			
Are you pregnant or nursing?			
Do you smoke?			
Have you ever smoked?			

Name: _____ Signature: _____ Date: _____

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