



Medical History

Patient's Name: _____ Today's date: _____

What is the reason for your appointment (please be as specific as possible)?: _____

Please indicate if you have an interest in any of the following:

Contact Lenses Refractive Surgery (LASIK)

List all medications you currently take (including aspirin, over-the-counter-medications, and home remedies):

Do you have any drug allergies or drug adverse reaction(s)? No Yes

If yes, please explain: _____

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

Are you currently pregnant or nursing? No Yes

Do you currently wear glasses? No Yes

Do you wear contact lenses? No Yes

If yes, please indicate the type of contact lens: Rigid Soft Other

FAMILY HISTORY Please note any family (parents, grandparents, and/or siblings living or deceased) history for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatologic Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

SOCIAL HISTORY

Do you use tobacco products? No Yes If yes, type/amount/how long: _____

Do you drink alcohol? No Yes If yes, type/amount/how long: _____

Do you use recreational drugs? No Yes If yes, type/amount/how long: _____



REVIEW OF SYSTEMS

Do you or have you ever had problems in the following areas?

SYSTEM	NO	YES	?	NO	YES	?
CONSTITUTIONAL						
Fever, Weight Gain/Loss	___	___	___			
EARS, NOSE, MOUTH, THROAT						
Deafness	___	___	___			
Dry Mouth/Throat	___	___	___			
ENDOCRINE						
Diabetes	___	___	___			
Type 1 ___ Type 2 ___						
Pituitary Disorder	___	___	___			
Thyroid Disorder	___	___	___			
Hyper ___ Hypo ___						
EYES/VISION						
Cataracts	___	___	___			
Double Vision	___	___	___			
Eye Injury	___	___	___			
Glaucoma	___	___	___			
Lazy Eye	___	___	___			
Macular Degeneration	___	___	___			
Refractive Surgery	___	___	___			
Retinal Detachment	___	___	___			
Retinal Disease	___	___	___			
GENITOURINARY						
STD	___	___	___			
INTEGUMENTARY (Skin)						
Acne Rosacea	___	___	___			
Cancer	___	___	___			
LYMPHATIC/HEMATOLOGIC						
Anemia	___	___	___			
Leukemia	___	___	___			
NEUROLOGICAL						
Headaches	___	___	___			
Migraine	___	___	___			
Multiple Sclerosis	___	___	___			
Seizures	___	___	___			
PSYCHIATRIC						
Anxiety Disorder	___	___	___			
Dementia	___	___	___			
Depression	___	___	___			
Memory Loss	___	___	___			
Schizophrenia	___	___	___			
RESPIRATORY						
Asthma	___	___	___			
COPD	___	___	___			
Emphysema	___	___	___			
RHEUMATOLOGIC						
Ankylosing Spondylitis	___	___	___			
Crohn's Disease	___	___	___			
Myasthenia Gravis	___	___	___			
Rheumatoid Arthritis	___	___	___			
Sarcoidosis	___	___	___			
Sjogren's Syndrome	___	___	___			
Systemic Lupus Eryth.	___	___	___			
VASCULAR/CARDIOVASCULAR						
Elevated Cholesterol	___	___	___			
Heart Attack/Stroke	___	___	___			
High Blood Pressure	___	___	___			

Broadway Vision Source

A MEMBER OF



Former patients: please check here if no medical history change since last exam

Doctor's signature: _____ Date: _____