SPECS Eye Care Medical History

Name of Patient____ Today's Date______________

Please check any problems you have currently or have been diagnosed with in the past:

- ☐ Age-related macular degeneration
- ☐ Glaucoma
- ☐ Diabetes; last A1C:______; doctor who treats:___________
- ☐ Diabetic Retinopathy
- ☐ Dry Eyes
- ☐ Eye Infection
- ☐ Floaters/Flashes of light
- ☐ Iritis/Uveitis
- ☐ Retinal defects (tears, detachments)
- ☐ Eye Surgery: Type____________________
- ☐ Amblyopia/Patching
- ☐ Keratoconus
- ☐ Injury to Eyes
- ☐ Nystagmus

Do you have any other concerns with your eyes or vision? ☐ Yes ☐ No *If yes, please describe:

____

Do you currently wear? ☐ Glasses or ☐ Contact Lenses: please list the brand (if known) ____________________

How often do you sleep in your contact lenses?______________**How often do you replace them?**______________

Review of Systems (Check any that apply):

Constitutional
- ☐ developmental delays/disabilities
- ☐ cancer
- ☐ fever

Ears/Nose/Throat
- ☐ Hearing loss
- ☐ Allergies/sinusitis

Neurological
- ☐ Multiple Sclerosis
- ☐ Seizures
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Stroke
- ☐ Headaches/Migraines

Psychiatric
- ☐ Depression/Anxiety
- ☐ Attention deficit disorder

Cardiovascular
- ☐ High Blood pressure
- ☐ Heart disease

Respiratory
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Sleep Apnea

Gastrointestinal
- ☐ Crohn's
- ☐ Acid reflux

Genitourinary
- ☐ Kidney disease
- ☐ Prostate
- ☐ STD
- ☐ Pregnant/Nursing

Musculoskeletal
- ☐ Arthritis
- ☐ Fibromyalgia

Integumentary
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Cold Sores/Shingles

Endocrine
- ☐ Diabetes: Type 1 or Type 2
- ☐ Thyroid

Hematologic/Lymphatic
- ☐ Anemia
- ☐ High cholesterol

Allergy/Immunology
- ☐ Drug allergy:______________
- ☐ Environmental Allergy
- ☐ Rheumatoid arthritis
- ☐ Lupus
- ☐ Sjogren's Syndrome

Please list any other medical conditions:____

Please list any current medications (with dosage if known):______________________________

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Social History:

Do you smoke or use tobacco? ☐ No ☐ Yes: How much/often? ______________________________

Do you drink alcholol? ☐ No ☐ Yes: How much/often? ______________________________

Family History:

Does anyone in your **immediate** family **(parents, grandparents, siblings, children)** have any of the following medical conditions?
If yes, please **check** all that apply and **list who** next to the condition:

☐ Cataracts:	☐ Lazy Eye:	☐ High Blood Pressure:
☐ Macular Degeneration:	☐ Diabetic Retinopathy:	☐ Thyroid disease:
☐ Glaucoma:	☐ Cancer:	☐ Heart disease:
☐ Retinal detachment:	☐ Diabetes:	