# Santa Clara Ophthalmology
## Medical History Form

Please check the following conditions or symptoms you have or have had in the past.

### Medical History

___ AIDS/HIV
___ Anemia
___ Artificial Heart Valve
___ Asthma
___ Autoimmune Disease
___ Bleeding Disorder
___ Brain Tumor
___ Cancer (Type(s) ___________________)
___ Clotting Disorder
___ Diabetes (Type ____)
(Since when? _____________)
___ Emphysema
___ Epilepsy/Seizures
___ Hay Fever
___ Headache
___ Heart Attack/Failure
___ Heart Murmur
___ Hepatitis (Type: ____)
___ High Blood Pressure
___ High Cholesterol
___ Irregular Heartbeat
___ Kidney Disease or Dialysis
___ Leukemia
___ Lymphoma
___ Lupus
___ Migraine Headaches
___ Multiple Sclerosis
___ Organ Transplant (Organ(s) __________)
___ Pacemaker
___ Rheumatoid Arthritis
___ Sarcoidosis
___ Sexually Transmitted Disease
___ Shingles (Zoster)
___ Skin Conditions
___ Stroke
___ Thyroid Disease
___ Tuberculosis
___ Drink Alcohol
___ Smoke Cigarettes (Packs Per Day ____)
___ Illicit Drug Use (Explain _____________)
___ Are You Currently Pregnant?

### Eye History

___ Blurriness
___ Burning
___ Cataracts
___ Crossed Eyes
___ Decreased Night Vision
___ Double Vision
___ Eyeglasses (Distance / Near / Bifocals)
___ Flashes
___ Floaters
___ Foreign Body Sensation
___ Glaucoma
___ Halos
___ Herpes/Shingles of Eye
___ Infection (Explain __________________)
___ Injury (Explain ____________________)
___ Itchiness
___ LASIK/PRK
___ Lazy Eye
___ Light Sensitivity
___ Loss of Vision
___ Macular Degeneration
___ Pain
___ Redness
___ Retinal Detachment or Tear
___ Surgery (Explain ___________________)
___ Tearing
___ Uveitis/Iritis
___ Other ___________________________

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### Contact Lens History (If Applicable)

Type ___ Soft ___ Hard

Brand(s) ______________________________

Disposable? ___ Yes ___ No

How many years have your worn contacts?
_______________________________________

How many hours a day do you wear them?
_______________________________________

How often do you replace them?
_______________________________________

Cleaning solution _______________________

Sleep in contacts? ___ Yes ___ No

### Past Surgical History & Dates

_______________________________________
_______________________________________
_______________________________________
_______________________________________
_______________________________________
_______________________________________
_______________________________________

### Current Oral Medications

_______________________________________
_______________________________________
_______________________________________
_______________________________________
_______________________________________
_______________________________________
_______________________________________
_______________________________________
_______________________________________
_______________________________________
_______________________________________

### Current Eye Drops

_______________________________________
_______________________________________
_______________________________________
_______________________________________
_______________________________________
_______________________________________
_______________________________________

### Allergies to Medications or Eye Drops (If Yes, Please Explain Reaction)

_______________________________________
_______________________________________
_______________________________________
_______________________________________
_______________________________________

### Family History

___ Blindness
___ Diabetes
___ Glaucoma
___ Hereditary Eye Disease
___ Macular Degeneration
___ Retinal Detachment or Tear
___ Other _____________________________