Bala Ambati, MD
Physician and Surgeon
Robin Bautista, OD
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Bradley J. Lorenzen, OD
Optometric Physician
Omer Gal, MD
Physician and Surgeon

Medical & Ocular History Page 1 of 3

Date _____ Name of patient _____ Date of birth _____

Ocular History

- Have you had any changes in distance vision, like road signs? ❑ Yes ❑ No
- Any changes in near vision, like computer or reading distance? ❑ Yes ❑ No
- Any other changes in vision? _____
- Do you currently wear glasses? ❑ Yes ❑ No
- Do you currently wear contacts? ❑ Yes ❑ No
  - If no, have you ever tried? ❑ Yes ❑ No
- If you wear glasses, how old are the lenses? _____ How long since your last exam? _____

Medications

Please list all ALLERGIES to substances/medications:

_____ _____
_____ _____
_____ _____

Please list all CURRENT MEDICATIONS, including any eye medications:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Surgery Information

Please list any surgeries you have had, including eye surgeries: _____
_____
_____

Personal Health

- Alcoholism ❑ Yes ❑ No
- Allergies ❑ Yes ❑ No
  - Hay Fever
  - Seasonal
  - Head allergy
- Arthritis ❑ Yes ❑ No
- Blood disorder ❑ Yes ❑ No
- Bronchitis ❑ Yes ❑ No
- Cancer ❑ Yes ❑ No
- Depression ❑ Yes ❑ No
- Diabetes ❑ Yes ❑ No
  - Since: _____
  - Type: _____
  - Insulin ❑ Yes ❑ No
- Drug Abuse ❑ Yes ❑ No
- Flu Shots ❑ Yes ❑ No
- Headaches ❑ Yes ❑ No
- Migraines ❑ Yes ❑ No
- Heart Attack ❑ Yes ❑ No
- Heart Disease ❑ Yes ❑ No

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Medical & Ocular History Page 2 of 3

- High blood pressure ❑ Yes ❑ No
- High Cholesterol ❑ Yes ❑ No
- HIV\AIDS ❑ Yes ❑ No
- Joint pain ❑ Yes ❑ No
- Kidney disease ❑ Yes ❑ No
- Lung problems ❑ Yes ❑ No
- MS ❑ Yes ❑ No
- Nose (Sinus) ❑ Yes ❑ No
- Pregnancy ❑ Yes ❑ No
- Seizures ❑ Yes ❑ No
- Stroke ❑ Yes ❑ No
- TB ❑ Yes ❑ No
- Throat (Dry Throat) ❑ Yes ❑ No
- Stomach ulcer ❑ Yes ❑ No
- Other issues: _____

FAMILY History

- Cancer ❑ Yes ❑ No
  - Who? _____
- Cardiovascular disease ❑ Yes ❑ No
  - Who? _____
- Diabetes ❑ Yes ❑ No
  - Who? _____
- Blindness ❑ Yes ❑ No
  - Who? _____
- Cataract ❑ Yes ❑ No
  - Who? _____
- Macular Degeneration ❑ Yes ❑ No
  - Who? _____
- Retinal Detachment ❑ Yes ❑ No
  - Who? _____
- Glaucoma ❑ Yes ❑ No
  - Who? _____
- Hypertension ❑ Yes ❑ No
  - Who? _____
- Stroke ❑ Yes ❑ No
  - Who? _____

Social History

- Smoker ❑ Yes ❑ No
  - If Yes, how many packs a day _____
- Recreational drug user ❑ Yes ❑ No
  - If Yes, which? _____
  - _____
  - _____
- Alcohol ❑ Yes ❑ No
  - Daily
  - Weekly
  - Monthly

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Medical & Ocular History Page 3 of 3

Review of Systems

- Eyes
  - Previous Surgery ❑ Yes ❑ No
  - Contact Lens ❑ Yes ❑ No
  - Pain ❑ Yes ❑ No
  - Double Vision ❑ Yes ❑ No
  - Glaucoma ❑ Yes ❑ No
  - Cataracts ❑ Yes ❑ No
  - Macular Degeneration ❑ Yes ❑ No
  - Dry Eyes ❑ Yes ❑ No
  - Flashes ❑ Yes ❑ No
  - Floaters ❑ Yes ❑ No
- Ear, Nose, and Throat
  - Hard of Hearing ❑ Yes ❑ No
  - Ringing in Ears ❑ Yes ❑ No
  - Vertigo ❑ Yes ❑ No
- Cardiovascular
  - Chest Pain ❑ Yes ❑ No
  - Dizziness ❑ Yes ❑ No
  - Fainting Spells ❑ Yes ❑ No
  - Shortness of Breath ❑ Yes ❑ No
  - Irregular Heart Beat ❑ Yes ❑ No
  - Difficulty Laying Flat ❑ Yes ❑ No
- Constitutional
  - Fatigue/Weakness ❑ Yes ❑ No
  - Fever ❑ Yes ❑ No
  - Weight Gain/Loss ❑ Yes ❑ No
- Respiratory
  - Cough ❑ Yes ❑ No
  - Congestion ❑ Yes ❑ No
  - Wheezing ❑ Yes ❑ No
  - Asthma ❑ Yes ❑ No
- Gastrointestinal
  - Heartburn ❑ Yes ❑ No
  - Nausea/Vomiting ❑ Yes ❑ No
  - Jaundice/Hepatitis ❑ Yes ❑ No
- Genito-Urinary
  - Pain/Difficulty ❑ Yes ❑ No
  - Blood in Urine ❑ Yes ❑ No
  - History of Kidney Stones ❑ Yes ❑ No
  - History of STDs ❑ Yes ❑ No
- Psychiatric
  - Anxiety/Depression ❑ Yes ❑ No
  - Mood Swings ❑ Yes ❑ No
  - Difficulty Sleeping ❑ Yes ❑ No
- Endocrine
  - Increased Thirst ❑ Yes ❑ No
  - Increased Hunger ❑ Yes ❑ No
  - Increased Urination ❑ Yes ❑ No
  - Increased Sweating ❑ Yes ❑ No
  - Fingernail Changes ❑ Yes ❑ No
- Blood/Lymph nodes
  - Easy Bruising ❑ Yes ❑ No
  - Gums Bleed Easily ❑ Yes ❑ No
  - Prolonged Bleeding ❑ Yes ❑ No
  - Heavy Aspirin Use ❑ Yes ❑ No
- Musculoskeletal
  - Stiffness ❑ Yes ❑ No
  - Arthritis ❑ Yes ❑ No
  - Joint Pain/Swelling ❑ Yes ❑ No
- Skin
  - Rash/Sores ❑ Yes ❑ No
  - Lesions ❑ Yes ❑ No
  - Hives/Eczema ❑ Yes ❑ No
- Neurological
  - Seizures ❑ Yes ❑ No
  - Weakness/Paralysis ❑ Yes ❑ No
  - Numbness ❑ Yes ❑ No
  - Tremors ❑ Yes ❑ No
- Immunologic
  - Hives ❑ Yes ❑ No
  - Itching ❑ Yes ❑ No
  - Runny Nose ❑ Yes ❑ No
  - Sinus Pressure ❑ Yes ❑ No