Confidential Medical History

Berkeley School of Optometry

Name: _____

Birthdate: _____

Date: _____

Primary Care Provider's Name: _____

Primary Care Provider's Contact Info: _____

Date of Last Routine Physical Exam: _____ Height: _____ Weight: _____

Date of Last Routine Bloodwork: _____ Pregnant: ☐ Yes ☐ No Nursing: ☐ Yes ☐ No

Any abnormal or notable findings flagged during the last routine bloodwork? ☐ Yes ☐ No

List any allergies to medicines: _____

List any medications that you take: (*include birth control pills, eye drops, over the counter medications, home remedies, homeopathic medications, vitamins, and alternative remedies*)

Do you or your family have a history of:

Glaucoma	☐ Yes	☐ No	☐ Family
Cataracts	☐ Yes	☐ No	☐ Family
Macular Degeneration	☐ Yes	☐ No	☐ Family
Eye Injury	☐ Yes	☐ No	
Retinal Disease	☐ Yes	☐ No	☐ Family
Blindness	☐ Yes	☐ No	☐ Family
Strabismus	☐ Yes	☐ No	☐ Family
Amblyopia	☐ Yes	☐ No	☐ Family
Dry Eyes	☐ Yes	☐ No	☐ Family
Eye surgery	☐ Yes	☐ No	☐ Family

Do you have a history of:

Constitution (fever, weight changes)	☐ Yes	☐ No
Integumentary (Skin) (rosacea, rashes)	☐ Yes	☐ No
Neurological (headaches, migraines, seizures)	☐ Yes	☐ No
Ear Nose, Throat (sinus congestion, sore throat)	☐ Yes	☐ No
Respiratory (asthma, emphysema, chronic bronchitis)	☐ Yes	☐ No
Cardiovascular (heart disease, high cholesterol, high blood pressure)	☐ Yes	☐ No
Gastrointestinal (chronic diarrhea, ulcers)	☐ Yes	☐ No
Genitourinary (kidney disease, bladder infections, IBD)	☐ Yes	☐ No
Musculoskeletal (arthritis, back pain, neck pain)	☐ Yes	☐ No
Hematologic/Lymphatic (anemia, bleeding problems)	☐ Yes	☐ No
Endocrine (diabetes, thyroid, hormone dysfunction)	☐ Yes	☐ No
Psychiatric (depression, anxiety)	☐ Yes	☐ No
Allergy/Immune System (seasonal allergies, immune deficiency)	☐ Yes	☐ No

Other: _____

Please provide detail for any YES answers below. Indicate any additional ocular history facts or comments including tired eyes, double vision, flashes, floaters, itchy/burning eyes, major injuries, surgeries, hospitalizations, etc.

SOCIAL HISTORY:

Occupation:

Hobbies:

Alcohol:
☐ _____ drinks per week

Tobacco:
☐ Current Smoker
_____ packs per day
_____ packs per week
☐ Former Smoker
☐ Never a Smoker

Desktop Computer Use: ☐ Yes _____ hours/day
Laptop Computer Use: ☐ Yes _____ hours/day
Tablet Use: ☐ Yes _____ hours/day
Smartphone Use: ☐ Yes _____ hours/day