DRS. DRIVER & CLARK, P.A.
HISTORY FORM

Name: ____ **Date:** ________________________

OCULAR:

If your last eye examination was not with our doctors who was it with and when?____

Please check any that you use:

- [ ] Eyeglasses
- [ ] Sunglasses
- [ ] Contact Lenses
- [ ] Readers / Magnifiers

MEDICAL:

PLEASE ATTACH A LIST OF YOUR MEDICATIONS

Who is your family doctor & when was your last medical exam? ____

What medications are you allergic to? ____

Please list major surgeries, hospitalizations or severe injuries you have had: ____

____

____

SOCIAL:

Do you drive? Yes___ No___ Live alone? Yes___ No ___ Pregnant or Nursing? Yes___ No___ Have indoor pets? Yes___ No___

Please check any that you consume:

- [ ] Tobacco Products
- [ ] Alcohol
- [ ] Vitamins / Supplements
- [ ] Recreational Drugs

FAMILY HISTORY: *Please check if any apply to your parent, grandparents, siblings, aunt, or uncle:*

- [ ] Cataracts / Implants
- [ ] Glaucoma
- [ ] Macular Degeneration
- [ ] Cancer
- [ ] Diabetes
- [ ] Heart Disease

REVIEW OF YOUR BODY SYSTEMS (ROS): *Please check any of the following that apply to you.*

EYES:

- [ ] **Loss of Vision**
- [ ] **Blurred Vision**
- [ ] **Sudden Blindness**
- [ ] **Halos**
- [ ] **Blind Spots**
- [ ] **Double Vision**
- [ ] **Light Flashes**
- [ ] **Floaters**
- [ ] **Wavy Lines**
- [ ] **Itchiness**
- [ ] **Dryness**
- [ ] **Watery**
- [ ] **Styes**
- [ ] **Crossed Eyes**
- [ ] **Lazy Eye**
- [ ] **Droopy Lid**
- [ ] **Glaucoma**
- [ ] **Cataract**
- [ ] **Lens Implant**
- [ ] **Retina Condition**
- [ ] **Eye Injuries**
- [ ] **NONE**

CONSTITUTIONAL:

- [ ] **Frequent Fevers**
- [ ] **Changes in Weight**
- [ ] **Overweight**
- [ ] **NONE**

GENITOURINARY:

- [ ] **Bladder Condition**
- [ ] **Kidney Problems**
- [ ] **Prostate Issues**
- [ ] **NONE**

ENDOCRINE:

- [ ] **Thyroid**
- [ ] **Para Thyroid**
- [ ] **NONE**

EAR, NOSE, THROAT:

- [ ] **Allergies**
- [ ] **Sinusitis**
- [ ] **Vertigo**
- [ ] ***Hearing Aids***
- [ ] **NONE**

GASTROINTESTINAL:

- [ ] **Constipation**
- [ ] **Diarrhea**
- [ ] **Chron's**
- [ ] **Reflux / GERD**
- [ ] **NONE**

PSYCHIATRIC:

- [ ] **Depression**
- [ ] **Anxiety**
- [ ] **Bipolar**
- [ ] **PTSD**
- [ ] **NONE**

VASCULAR:

- [ ] **Diabetes**
- [ ] **Heart Condition**
- [ ] **Blood Pressure**
- [ ] **Cholesterol**
- [ ] **NONE**

IMMUNOLOGIC:

- [ ] **HIV**
- [ ] **AIDS**
- [ ] **Hepatitis**
- [ ] **NONE**

NEUROLOGICAL:

- [ ] **Migraines**
- [ ] **Seizures**
- [ ] **Stroke**
- [ ] **MS**
- [ ] **Dementia**
- [ ] **Alzheimer's**
- [ ] **Autism**
- [ ] **Neuropathy**
- [ ] **ADD / ADHD**
- [ ] **NONE**

RESPIRATORY:

- [ ] **Asthma**
- [ ] **COPD**
- [ ] **Oxygen Use**
- [ ] **NONE**

BLOOD, LYMPHATIC:

- [ ] **Anemia**
- [ ] **Bleeding Disorder**
- [ ] **NONE**

BONES, MUSCLES:

- [ ] **Arthritis**
- [ ] **Fibromyalgia**
- [ ] **Muscle Disorder**
- [ ] **Gout**
- [ ] **Back Pain**
- [ ] ***Cane***
- [ ] ***Walker***
- [ ] ***Wheelchair***
- [ ] **NONE**

INTEGUMENTARY:

- [ ] **Skin Condition**
- [ ] **NONE**

CANCER: (List)

- [ ] **NONE**

REVIEWED:

Doctor	Date	Doctor	Date	Doctor	Date	Doctor	Date	Doctor	Date

Doctor	Date	Doctor	Date	Doctor	Date	Doctor	Date	Doctor	Date