Dr. Brendon J. Johnson

Practice of Optometry & Contact Lens Care

Date__________ Date Updated__________
Date Updated__________ Date Updated__________
Date Updated__________ Date Updated__________

Patient: ______________________________________ **DOB:**__________

MEDICAL HISTORY

Do you have any allergies to medications: ☐ NO ☐ YES If yes, please explain: ____________________

What pharmacy do you use? ______________________________________

Current medications/vitamins/supplements you take and dosages: ____________________

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List any major injuries, surgeries, hospitalizations you have had: ____________________

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Are you pregnant and/or nursing? ☐ NO ☐ YES

FAMILY HISTORY (Please include parents, grandparents, siblings, children—living or deceased)

Disease/Condition		Relationship to you
Cataracts	☐ NO ☐ YES	
Glaucoma	☐ NO ☐ YES	
Macular Degeneration	☐ NO ☐ YES	
Retinal Disease	☐ NO ☐ YES	
Arthritis	☐ NO ☐ YES	
Cancer	☐ NO ☐ YES	
Diabetes	☐ NO ☐ YES	
Heart Disease	☐ NO ☐ YES	
High Blood Pressure	☐ NO ☐ YES	
Lupus	☐ NO ☐ YES	
Thyroid Disease	☐ NO ☐ YES	

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the Doctor, if you prefer.

Do you drive? ☐ NO ☐ YES Do you have difficulty when driving? ☐ NO ☐ YES

Do you use tobacco products? ☐ NO ☐ YES If yes, type/amount/how long: ____________________

Do you use illegal drugs? ☐ NO ☐ YES If yes, type/amount/how long: ____________________

Do you drink alcohol? ☐ NO ☐ YES If yes, type/amount/how long: ____________________

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ Chlamydia

Over

REVIEW OF SYMPTOMS Do you currently have or have you ever had any problems in the following areas?

Constitutional

Fever	☐ NO	☐ YES
Weight Loss	☐ NO	☐ YES
Integumentary (Skin)	☐ NO	☐ YES

Neurological

Headaches	☐ NO	☐ YES
Migraines	☐ NO	☐ YES
Seizures	☐ NO	☐ YES

Eyes

Loss of Vision	☐ NO	☐ YES
Blurred Vision	☐ NO	☐ YES
Distorted Vision/Halos	☐ NO	☐ YES
Loss of Side Vision	☐ NO	☐ YES
Double Vision	☐ NO	☐ YES
Dryness	☐ NO	☐ YES
Mucous Discharge	☐ NO	☐ YES
Redness	☐ NO	☐ YES
Sandy/Gritty Feeling	☐ NO	☐ YES
Itching	☐ NO	☐ YES
Burning	☐ NO	☐ YES
Foreign Body Sensation	☐ NO	☐ YES
Excess Tearing/Watering	☐ NO	☐ YES
Glare/Light Sensitivity	☐ NO	☐ YES
Eye Pain/Soreness	☐ NO	☐ YES
Chronic Eye/Lid Infection	☐ NO	☐ YES
Sties or Chalazion	☐ NO	☐ YES
Flashes/Floaters in Vision	☐ NO	☐ YES
Tired Eyes	☐ NO	☐ YES

Endocrine

Thyroid/Other Glands	☐ NO	☐ YES
Immunologic	☐ NO	☐ YES
Diabetes	☐ NO	☐ YES

Ears, Nose, Mouth, Throat

Allergies/Hay Fever	☐ NO	☐ YES
Stuffy Nose	☐ NO	☐ YES
Post Nasal Drip	☐ NO	☐ YES
Chronic Cough	☐ NO	☐ YES
Dry Throat/Mouth	☐ NO	☐ YES
Earache	☐ NO	☐ YES

Respiratory

Asthma	☐ NO	☐ YES
Chronic Bronchitis	☐ NO	☐ YES
Emphysema	☐ NO	☐ YES

Vascular/Internal

Heart Disease	☐ NO	☐ YES
High Blood Pressure	☐ NO	☐ YES
Vascular Disease	☐ NO	☐ YES
Upset Stomach	☐ NO	☐ YES
Diarrhea	☐ NO	☐ YES
Constipation	☐ NO	☐ YES
Genitourinary	☐ NO	☐ YES
Genitals/Kidney/Bladder	☐ NO	☐ YES

Bones/Joints/Muscles

Rheumatoid Arthritis	☐ NO	☐ YES
Joint Pain	☐ NO	☐ YES

Lymphatic/Hematologic

Anemia	☐ NO	☐ YES
Bleeding Problems	☐ NO	☐ YES
Cancer	☐ NO	☐ YES

Psychiatric

Depression	☐ NO	☐ YES

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Have you ever had any of the following: ☐ Crossed Eyes ☐ Lazy Eyes ☐ Drooping Eyelid ☐ Bulging eyes
☐ Glaucoma ☐ Macular Degeneration ☐ Cataracts ☐ Eye Infections ☐ Eye Injury ☐ Eye Surgery____________

Name of Medical Doctor:____________________________________ Last Medical Exam____________

Name of Last Eye Doctor (if not here):____________________________ Last Eye Exam____________

Do you wear glasses? ☐ NO ☐ YES Age of glasses:____________________

Do you wear contact lenses? ☐ NO ☐ YES How old is your present pair of contacts?____________________

What brand of contacts?____________________________

How often do you change your contacts?____________________

Academic History (for children 18 and under) Is the child achieving at expected levels in school? ☐ NO ☐ YES

Indicate any of these symptoms when reading: ☐ Poor comprehension ☐ Poor memory ☐ Fatigue ☐ Works Slowly
☐ Seems too hard ☐ Avoidance ☐ Headaches during or after ☐ Eyestrain ☐ Loses place ☐ Can't stay on task