

**LONGMEADOW OPTICAL, LTD.**

PATIENT NAME: \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ GENERAL MEDICAL HISTORY:  
CHECK ALL THAT APPLY

	NAME OF MEDICAL DOCTOR: _____	
DIABETES (WHEN DIAGNOSED _____)	_____	ASTHMA _____
HIGH BLOOD PRESSURE	_____	EMPHYSEMA _____
HEART DISEASE	_____	MIGRAINES _____
CAROTID ARTERY DISEASE	_____	CANCER _____
THYROID: HYPO OR HYPER?	_____	LUPUS _____
IRRITABLE BOWEL SYNDROME	_____	HIV+ _____
ARTHRITIS: RHEUMATOID OR OSTEO?	_____	SINUS _____
BLEEDING DISORDER	_____	HEPATITIS _____
HIGH CHOLESTEROL	_____	PREGNANT _____
KIDNEY DISEASE	_____	LYME DISEASE _____
ACNE ROSACEA	_____	DEPRESSION _____
SJOGREN'S SYNDROME	_____	ANXIETY _____
MULTIPLE SCLEROSIS	_____	
OTHER CONDITIONS NOT MENTIONED: _____		

LIST ANY OPERATIONS AND HOSPITALIZATIONS WITH APPROXIMATE DATES:  
\_\_\_\_\_

MEDICATIONS: (INCLUDE PRESCRIPTION MEDICINES, EYE DROPS, VITAMINS, HERBALS, AND OVER THE COUNTER MEDICINES) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ALLERGIES TO:

MEDICATIONS	YES	NO	_____
EYE DROPS	YES	NO	_____
OTHER (ENVIRONMENTAL)	YES	NO	_____

EYE HISTORY: (CHECK ALL THAT APPLY)

GLAUCOMA	_____	CATARACTS	_____
LAZY EYE	_____	AMBLYOPIA	_____
RETINAL DISEASE	_____	RETINAL DETACHMENT	_____
ALLERGIES	_____	DRY EYE	_____

DATE OF LAST EXAM: \_\_\_\_\_

DO YOU WEAR GLASSES? YES NO (FOR DISTANCE, NEAR, OR BOTH?) \_\_\_\_\_

DO YOU WEAR CONTACT LENSES? YES NO (SOFT OR RIGID GAS PERMEABLE?) \_\_\_\_\_

LIST ALL PAST EYE INJURIES AND EYE SURGERIES WITH APPROXIMATE DATES:  
\_\_\_\_\_  
\_\_\_\_\_

FAMILY HISTORY:                      RELATION TO PATIENT (LIST ANY OTHER EYE OR MEDICAL CONDITIONS IN YOUR FAMILY)

GLAUCOMA	YES	NO	_____	_____
MACULAR DEGENERATION	YES	NO	_____	_____
RETINAL DETACHMENT	YES	NO	_____	_____
BLINDNESS	YES	NO	_____	_____

SOCIAL HISTORY:

SMOKE?            NEVER            FORMER, QUIT \_\_\_\_\_ YEARS AGO            CURRENT (HOW MUCH) \_\_\_\_\_

DRINK ALCOHOL?    NEVER            <1 DRINK/DAY            >1 DRINK/DAY (HOW MUCH) \_\_\_\_\_

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_