Covina Hills
Optometric Group

Dr. Perry Hom
Dr. Francine Horibe
Dr. Carmen Gutierrez

PATIENT MEDICAL HISTORY FORM

**** This medical information will be added to your Electronic Health Record during your next vision examination. This form will only have to be completed ONE TIME for each patient. The information will be electronically updated during all future examinations.***

REVIEW OF HEALTH SYSTEMS: *Check all that apply*

CONSTITUTION: ☐ Developmental Disability ☐ Cancer ☐ Chronic Fatigue Syndrome ☐ Other _____
EAR NOSE THROAT: ☐ Hearing Loss ☐ Sinusitis ☐ Dry Mouth ☐ Laryngitis ☐ Other _____
NEUROLOGICAL: ☐ Multiple Sclerosis ☐ Epilepsy ☐ Cerebral Palsy ☐ Tumor ☐ Migraine ☐ Autism/ASD ☐ Other _____
PSYCHOLOGICAL: ☐ Depression ☐ ADD/ADHD ☐ Anxiety Disorder ☐ Bipolar Disorder ☐ Other _____
CARIOVASCULAR: ☐ High Blood Pressure ☐ Stroke/CVA ☐ Heart Disease ☐ Vascular Disease ☐ Congestive Heart Failure ☐ Other _____
RESPIRATORY: ☐ Cigarette Smoker ☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ COPD ☐ Sleep Apnea ☐ Other _____
GI: ☐ Crohn's Disease ☐ Colitis ☐ Ulcers ☐ Acid Reflux ☐ Celiac Disease ☐ Other _____
GU: ☐ Kidney Disease ☐ Prostate Cancer/Disease ☐ STD ☐ Benign Prostate Hypertrophy ☐ Pregnancy ☐ Nursing ☐ Herpes ☐ Chlamydia
MUSCULO-SKELETAL: ☐ Osteoarthritis ☐ Fibromyalgia ☐ Muscular Dystrophy ☐ Ankylosing Spondylitis ☐ Osteoporosis ☐ Gout ☐ Other _____
INTEG/SKIN: ☐ Eczema ☐ Rosacea ☐ Psoriasis ☐ Cold Sores ☐ Shingles ☐ Other _____
ENDOCRINE: ☐ Type 2 Diabetes ☐ Type 1 Diabetes ☐ Thyroid Dysfunction ☐ Hormonal Dysfunction ☐ Other _____
BLOOD/LYMPH: ☐ Anemia ☐ Large-volume Blood Loss ☐ Ulcer ☐ High Cholesterol ☐ Other _____
ALLERGY/IMMUNOLOGIC: ☐ Drug Allergies ☐ Environmental Allergies ☐ Rheumatoid Arthritis ☐ Lupus ☐ Sjogren's Syndrome ☐ Other _____

CURRENT MEDICATIONS: *Check all that apply*

☐ NONE
☐ See ATTACHED LIST
☐ ***Please list all medications the patient is currently taking (if list is NOT attached):***

ALLERGIES: *Check all that apply*

☐ NONE
☐ **DRUG** Allergies: ***Please list all DRUGS is the patient allergic to:***

☐ **OTHER** Allergies:
- ☐ Bee Sting
- ☐ Environmental
- ☐ Food: ☐ Dairy ☐ Nuts ☐ Shellfish ☐ Other _____
- ☐ Latex

ADDITIONAL EYE TREATMENTS / CONDITIONS: *Check all that apply*

- ☐ KERATOCONUS: ☐ RIGHT eye ☐ LEFT eye
- ☐ EYE INJURY: ☐ RIGHT eye ☐ LEFT eye Type of injury:_____ Date of injury:_____
- ☐ EYE SURGERY: ☐ RIGHT eye ☐ LEFT eye Type of surgery:_____ Date of surgery:_____
- ☐ EYE PATCHING: ☐ RIGHT eye ☐ LEFT eye Hours per day:_____ Dates of patching:_____
- ☐ STRABISUMUS/EYE DRIFT: ☐ RIGHT eye ☐ LEFT eye
- ☐ AMBLYOPIA
- ☐ NYSTAGMUS
- ☐ OTHER _____

SOCIAL HISTORY: *Check all that apply*

- ☐ ALCOHOL USE: Amount: ☐ Heavy ☐ Light
- ☐ TOBACCO USE: ☐ Former ☐ Current
  - TYPE: ☐ Cigarette ☐ Cigar ☐ Pipe ☐ Smokeless tobacco ☐ Other _____
  - Amount: ☐ Heavy ☐ Light

HOBBIES, INTERESTS, ACTIVITIES: *Please list*

***FAMILY* MEDICAL HISTORY:** *Check all that apply*

☐ HIGH BLOOD PRESSURE	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ TYPE I DIABETES	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ TYPE 2 DIABETES	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ Overactive/HYPERTHYROID	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ Underactive/HYPOTHYROID	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ CANCER	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Son	☐ Daughter

***FAMILY* EYE HISTORY:** *Check all that apply*

☐ GLAUCOMA	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ MACULAR DEGENERAGION	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Son	☐ Daughter
☐ CATARACT	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Son	☐ Daughter

CONTACT LENS HISTORY: *Check all that apply*

- ☐ Former contact lens wearer
- ☐ Current contact lens wearer

Brand:_____

Lens Replacement Schedule: ☐ Daily ☐ Every 2 weeks ☐ Monthly ☐ Other:_____

ARE ANY EYE CONDITIONS RELATED TO: *Check all that apply*

- ☐ EMPLOYMENT
- ☐ AUTO ACCIDENT ☐ RIGHT eye ☐ LEFT eye Accident Date: _____
- ☐ OTHER ACCIDENT ☐ RIGHT eye ☐ LEFT eye Accident Date: _____

_____ _____

Signature of Patient, Parent, or Guardian Date