Medical History

Hudson Valley Eye Doctor

Elaina M. Groo, O.D.

Last Name _____ First Name _____ Today's Date _____

Date of Birth _____ Date of Last Eye Exam _____ Physician _____

Date of Last Physical Exam _____ Physician(s)_____

List any medications you currently take (prescription and or over the counter): _____

_____

_____

Do you have any allergies or allergies to medication? Yes NO If yes, list the medications:

_____

List all major illnesses (high blood pressure, diabetes, heart attack, glaucoma, etc.) or injuries (concussion, etc.):

_____

_____

List any surgeries /and or hospitalizations you have had (ie. tonsillectomy, appendectomy, cataract)

_____

_____

Diabetes Only:(*circle*) Insulin Dependant: how many years_____Non-Insulin Dependant: how many years_____

Last Blood Sugar:_____Hemaglobin A1C_____ Reported Under Control YES NO

Are you pregnant and or nursing? Yes [ ] NO [ ]

Do you wear glasses? Yes [ ] NO [ ] If yes, how old is your present pair of lenses?_____

Do you wear contact lenses? Yes [ ] NO [ ] If yes, how old is your present pair of lenses?_____

Type of contact lenses? [ ] Ridgid [ ] Soft [ ] Extended Wear [ ] Other_____Are they comfortable? [ ] Yes [ ] NO

Contact Lens Brand and Power Right Eye:_____Left Eye_____

What type of disinfection system do you use? _____

Do you currently have any problems in the following areas? If "yes", please provide information.

	YES	NO	
EYES (glaucoms, cataracts, retinal disease, etc)			
Loss of Vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Loss of side vision			
Double Vision			
Dryness			
Mucous discharge			
Redness			
Sandy or grity feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid (stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping Eyelid			
Flashes/Floaters			
Visual Fatigue			
Pain			

Please continue on back