AMWELL EYE CARE
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MEDICAL HISTORY (PLEASE PRINT)

Patient Name:_____ Date: _____

Date of last eye examination:_____ Date of Birth:_____

MAIN REASON for today's visit:_____

EYE HISTORY

How old are your glasses?_____

Do you wear contact lenses? yes ☐ no ☐

If yes, brand/name of contacts:_____

Are you interested in contact lenses? yes ☐ no ☐

If yes, choose: ☐new ☐color ☐overnight vision correction ☐bifocal

Check all that apply:

Eye injury (if yes, specify_____)	yes ☐	no ☐
Eye surgery (if yes, specify_____)	yes ☐	no ☐
Eye turn or cross-eyed	yes ☐	no ☐
Lazy eye or amblyopia	yes ☐	no ☐
Cataract	yes ☐	no ☐
Glaucoma	yes ☐	no ☐
Other eye disease (if yes, specify_____)	yes ☐	no ☐
Family history of glaucoma (if yes, specify_____)	yes ☐	no ☐
Family history of any other eye disease (if yes, specify_____)	yes ☐	no ☐

Eye Drops (list all eye drops you use and how often)

_____

_____

_____

Medications (including prescription and over-the-counter)

_____

_____

_____

MEDICAL HISTORY

Check all that apply:

Cardiovascular high blood pressure, chest pain, stroke	yes ☐	no ☐
Endocrine diabetes, thyroid conditions, renal disorder (If diabetic, type_____years_____)	yes ☐	no ☐
Respiratory asthma, shortness of breath, bronchitis	yes ☐	no ☐
Gastrointestinal heartburn, diarrhea, vomiting, stomach pain	yes ☐	no ☐
Urinary pain or discomfort, blood in urine	yes ☐	no ☐
Musculoskeletal muscle aches, joint pain, swollen joints	yes ☐	no ☐
Neurological numbness, weakness, paralysis	yes ☐	no ☐
Immunological lupus, sarcoidosis, multiple sclerosis	yes ☐	no ☐
Skin rashes, excessive dryness, acne	yes ☐	no ☐
Psychiatric depression, anxiety	yes ☐	no ☐
Chronic fever, unexplained weight loss/gain, fatigue	yes ☐	no ☐
Ear/nose/throat hearing loss, sore throat, sinus problems	yes ☐	no ☐
Blood disease sickle cell, hematological disorder	yes ☐	no ☐
Other medical conditions not noted above pregnancy, cancer, stroke (if yes, specify_____)	yes ☐	no ☐
Allergies Hay fever, pollen, allergy to medications (if yes, specify_____)	yes ☐	no ☐
Do you smoke or drink alcohol? (if yes, specify_____)	yes ☐	no ☐