MEDICAL HISTORY

KARL M. LARSEN, O.D., LTD
7324 W. CHEYENNE AVE., STE 1
LAS VEGAS, NV 89129
259-EYES (3937)

PATIENT'S NAME ___________________________

When updating, ✔ 'same' or 'update' and make changes if needed.

TODAY'S DATE ______________________________

MEDICAL HISTORY

1. Do you have any allergies to medications?
If yes, please list: ____________________________
____

2. List any medication you take, including oral contraceptives, aspirin, over-the-counter medication and home remedies: ________________
____
____

3. List all medical conditions you are being treated for: ____
____

4. List all major injuries, surgeries and/or hospitalizations you have had: __________________
____
____

5. If female, are you pregnant or nursing? Y / N
6. Do you wear glasses? Y / N
7. Do you wear contact lenses? Y / N
If yes, type of contact lenses:
soft disposable gas permeable other _________

GENERAL HEALTH REVIEW
Do you currently have or ever had problems in the following area?

NEUROLOGICAL		
Headaches	Yes	No
Migraines	Yes	No
Seizures	Yes	No
EYES		
Flashes/Floaters in Vision	Yes	No
Amblyopia (Lazy Eye)	Yes	No
Blurred Vision	Yes	No
Chronic Infection of Eye or Lid	Yes	No
Distorted Vision/Halos	Yes	No
Double Vision	Yes	No
Dryness/Gritty Feeling	Yes	No
Excess Tearing/Watering	Yes	No
Eye Pain or Soreness	Yes	No
Eye Surgery	Yes	No
Foreign Body Sensation	Yes	No
Glare/Light Sensitivity	Yes	No
Itching/Burning	Yes	No
Loss of Vision	Yes	No
Redness	Yes	No
Retina Detachment	Yes	No

Over ↓

UPDATE #1 DATE ___________

MEDICAL HISTORY

1. ____ Same as previous visit
____ Update
____

2. ____ Same as previous visit
____ Update
____
____
____

3. ____ Same as previous visit
____ Update
____

4. ____ Same as previous visit
____ Update
____
____

5. ___ Same ___ Update Y/N
6. ___ Same ___ Update Y/N
7. ___ Same ___ Update Y/N
New type of contact lenses:
____

GENERAL HEALTH REVIEW
____ Same as previous visit
____ Update

NEUROLOGICAL		
	Yes	No
	Yes	No
	Yes	No
EYES		
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No

Over ↓

UPDATE #2 DATE__________

MEDICAL HISTORY

1. ____ Same as previous visit
____ Update
____

2. ____ Same as previous visit
____ Update
____
____
____

3. ____ Same as previous visit
____ Update
____

4. ____ Same as previous visit
____ Update
____
____

5. ___ Same ___ Update Y/N
6. ___ Same ___ Update Y/N
7. ___ Same ___ Update Y/N
New type of contact lenses:
____

GENERAL HEALTH REVIEW
____ Same as previous visit
____ Update

NEUROLOGICAL		
	Yes	No
	Yes	No
	Yes	No
EYES		
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No
	Yes	No

Over ↓

MEDICAL HISTORY CONTINUED

EARS, NOSE, MOUTH, THROAT

Allergies/Hay Fever	Yes	No
Sinus Congestion/Runny Nose	Yes	No
Chronic Cough	Yes	No
Dry Throat/Mouth	Yes	No

RESPIRATORY

Asthma	Yes	No
Chronic Bronchitis	Yes	No
Emphysema/COPD	Yes	No

VASCULAR/CARDIOVASCULAR

Diabetes	Yes	No
High Blood Pressure	Yes	No
Heart/Vascular Disease	Yes	No

GASTROINTESTINAL

Diarrhea	Yes	No
Constipation	Yes	No

GENITOURINARY

Genitals/Kidney/Bladder	Yes	No

BONES/JOINTS/MUSCLES

Rheumatoid Arthritis	Yes	No
Muscle Pain	Yes	No
Joint Pain	Yes	No

OTHER: ____________________________________

FAMILY HISTORY Have any family members, (parents, grandparents, siblings, or children) ever had any of the following diseases/conditions:

Amblyopia (Lazy Eye)	Yes	No
Arthritis	Yes	No
Blindness	Yes	No
Cancer	Yes	No
Cataract	Yes	No
Crossed Eyes	Yes	No
Diabetes	Yes	No
Glaucoma	Yes	No
Heart Disease	Yes	No
High Blood Pressure	Yes	No
Kidney Disease	Yes	No
Macular Degeneration	Yes	No
Retinal Detachment/Disease	Yes	No
Thryoid Disease	Yes	No

OTHER: ____________________________________

SOCIAL HISTORY

This information is kept confidential. If you prefer, you may discuss this directly with your doctor.

1. Do you use tobacco products?	Yes	No
2. Do youdrink alcohol?	Yes	No
3. Do you use illegal drugs?	Yes	No

The above information is accurate to the best of my knowledge.

Signature: ____________________________________

UPDATE #1 CONTINUED

EARS, NOSE, MOUTH, THROAT

Yes No
Yes No
Yes No
Yes No

RESPIRATORY

Yes No
Yes No
Yes No

VASCULAR/CARDIOVASCULAR

Yes No
Yes No
Yes No

GASTROINTESTINAL

Yes No
Yes No

GENITOURINARY

Yes No

BONES/JOINTS/MUSCLES

Yes No
Yes No
Yes No

OTHER: ________________

FAMILY HISTORY

____ Same as previous visit
____ Update

Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No

OTHER: ___________________

SOCIAL HISTORY

____ Same as previous visit
____ Update

1.	Yes	No
2.	Yes	No
3.	Yes	No

Update #2 is accurate.

_____________ Initials

UPDATE #2 CONTINUED

EARS, NOSE, MOUTH, THROAT

Yes No
Yes No
Yes No
Yes No

RESPIRATORY

Yes No
Yes No
Yes No

VASCULAR/CARDIOVASCULAR

Yes No
Yes No
Yes No

GASTROINTESTINAL

Yes No
Yes No

GENITOURINARY

Yes No

BONES/JOINTS/MUSCLES

Yes No
Yes No
Yes No

OTHER: ________________

FAMILY HISTORY

____ Same as previous visit
____ Update

Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No
Yes No

OTHER: _________________

SOCIAL HISTORY

____ Same as previous visit
____ Update

1.	Yes	No
2.	Yes	No
3.	Yes	No

Update #3 is accurate

___________ Initials