SHIGIO OPTOMETRIC GROUP

Name ______________________________

Patient Medical History

Name of Family Physician ____________________
City/Location ______________________________
Date of Last Physical Exam ___________________

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins and birth control pills ______________________
____
____

Allergies to medications? ☐Yes ☐No
If so, what medications? ____________________
____

Have you had any surgeries? ☐Yes ☐No
Do you use cigarettes/tobacco, alcohol, or other substances? ☐Yes ☐No

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Allergies	☐	☐
Arthritis	☐	☐
Blood/Lymph	☐	☐
Bronchitis	☐	☐
Cancer	☐	☐
Cholesterol	☐	☐
Diabetes	☐	☐
Ears/Nose/Throat	☐	☐
Endocrine	☐	☐
Eczema/Rashes	☐	☐
Genitourinary	☐	☐
High Blood Pressure	☐	☐
Neurological	☐	☐
Psychological	☐	☐
Respiratory	☐	☐
Sinus	☐	☐
Thyroid	☐	☐

Thank you for your trust in our office!

Ronald S. Shigio, O.D.
Lauri K. Shigio, O.D.

Today's Date ______________________________

Patient Eye History

Have you ever tried contact lenses? ☐Yes ☐No
Do you currently wear contact lenses? ☐Yes ☐No
What kind? ______________________________
Solutions used? ___________________________
Are you satisfied with the vision and comfort of your contact lenses? ☐Yes ☐No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
☐No ☐Yes (Please check boxes)

	Relationship (Mother's or Father's side)
Blindness	☐ ____________________
Cataracts	☐ ____________________
Corneal Problems	☐ ____________________
Diabetes	☐ ____________________
Glaucoma	☐ ____________________
Heart Disease	☐ ____________________
Lazy Eye	☐ ____________________
Macular Degeneration	☐ ____________________
Retinal Problems	☐ ____________________

Lifestyle Questions

Do you....(check box if your answer is yes)

☐ ...work at a computer?
☐ ...think you might benefit from thinner, lighter lenses?
☐ ...spend time outdoors? How much? _____ hrs/week
☐ ...have prescription sunwear?
☐ ...have interest in a non-surgical approach to vision
☐ ...prefer not to wear your glasses at times? When? ________
☐ ...have more than 1 pair of current Rx eyewear?

Have you ever experienced, been diagnosed or treated for any of the following?

☐Blurry Vision	☐Cataracts	☐Crossed eye/Eye turn
☐Eye Infections	☐Flash of Light	☐Glaucoma
☐Headaches	☐Itchiness	☐Macular Degeneration
☐Tearing	☐Burning	☐Retinal Detachment
☐Double Vision	☐Eye Injury	☐Corneal Abrasions
☐Grittiness	☐Iritis/Uveitis	☐Occasional Dryness
☐Lazy Eye	☐Floaters/Spots	☐Sunlight Sensitivity
☐Trouble seeing at night	☐Other eye disorders _____________	