Vision Source- Rapid City
Dwayne R. Ice, OD
825 Columbus St, Ste E
Rapid City, SD 57701
605-343-4703
www.visionsource-rapidcity.com

Patient Name: _____

Date: _____

Patient Medical History Form

Please complete the following form as thoroughly as possible. The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Eye History

Date of Last Eye Exam: _____

By Whom? _____

Have you had any eye-related surgeries of any kind?
☐ Yes ☐ No

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

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

Family Medical/Eye History

Do you have a family medical history of any of the following? (check all that apply and indicate mother or father's side):

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

Continued on next page…

Patient Medical History Form, Continued

Patient Medical History

Name of Family Physician: _____

_____

Address: _____

Date of Last Physical Check-Up: _____

Height:_____Weight:_____

Current Medications (Rx or Over-The-Counter)

(List name of medications, including eye drops, vitamins & birth control pills, dosages, and frequency. Please bring a list if possible!):_____

_____

_____

_____

_____

_____

Allergies to medications? ☐ Yes ☐ No

If so, what medications? _____

_____

_____

Do you use cigarettes/tobacco, alcohol, or other substances? ☐ Yes ☐ No

Patient Medical History, Cont.

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

	Yes	No
Allergies	☐	☐
Arthritis	☐	☐
Blood/Lymph	☐	☐
Bronchitis	☐	☐
Cancer	☐	☐
Cholesterol	☐	☐
Diabetes	☐	☐
Digestive	☐	☐
Ears/Nose/Throat	☐	☐
Endocrine	☐	☐
Eczema/Rashes	☐	☐
Fatigue	☐	☐
Fevers	☐	☐
Genitourinary	☐	☐
High Blood Pressure	☐	☐
Integumentary (Skin)	☐	☐
Kidney	☐	☐
Muscle/Bone	☐	☐
Neurological	☐	☐
Psychological	☐	☐
Respiratory	☐	☐
Sinus	☐	☐
Throat Infections	☐	☐
Thyroid	☐	☐
Unusual weight losses/gains	☐	☐