WESTMINSTER VISION ASSOCIATES

Medications and Medical History

Please complete this form, front and back.

Patient Name: _____
First Middle Last

Date of Birth: _____ Today's Date: _____

What's the main reason for your exam today?

❍ Yearly Exam ❍ Office Visit ❍ Poor Vision ❍ Glaucoma Check ❍ Can't pass driver's test

Do you wear:

❍ Glasses ❍ Contacts ❍ Both ❍ Neither

Medications

Antibiotics	**Blood Thinners**	❍ Insulin Glargine (Lantus)
❍ Amoxicillin	❍ Aspirin	❍ Insulin Detemir (Levemir)
❍ Azithromycin (Z-Pak)	❍ Dipyridamole (Aggrenox)	❍ Linaglipton (Tradjenta)
Allergy/Asthma/COPD	❍ Clopidogrel (Plavix)	❍ Liraglutide (Victoza)
❍ Albuterol (Proventil, Ventolin)	❍ Dabigatran (Pradaxa)	❍ Saxagliptin (Onglyza)
❍ Loratadine (Claritin)	❍ Rivaroxaban (Xarelto)	**Gastrointestinal**
❍ Montelukast (Singulair)	❍ Warfarin (Coumadin)	❍ Omeprazole (Prilosec)
❍ Fluticasone/Salmeterol (Advair)	**Cholesterol**	❍ Esomeprazole (Nexium)
Autoimmune	❍ Simvastatin (Zocor)	**HIV**
❍ Adalimumab (Humira)	❍ Rosuvastatin (Crestor)	❍ Atripla
❍ Infliximab (Remicade)	❍ Atorvastatin (Lipitor)	❍ Ritonavir (Norvir)
❍ Etanercept (Enbrel)	**Depression/Bipolar/Alzheimer's**	❍ Truvada
Blood Pressure	❍ Aripiprazole (Abilify)	**Pain**
❍ Amlodipine (Norvasc)	❍ Duloxetine (Cymbalta)	❍ Hydrocodone (Norco)
❍ Hydrochlorothiazide (HCTZ)	❍ Memantine (Namenda)	**Thyroid**
❍ Lisinopril (Zestril)	**Diabetes**	❍ Levothyroxine (Synthroid)
❍ Metoprolol (Toprol)	❍ Metformin (Glucophage)	
❍ Valsartan (Diovan)	❍ Sitagliptin (Januvia)	
❍ Olmesartan (Benicar)	❍ Insulin Aspart (Novolog)	
❍ Telmisartan (Micardis)	❍ Insulin Lispro (Novolog)	

Other, INCLUDING ANY EYE DROPS (Please Specify)**:**

_____

_____

Please continue on other side

Allergies

☐ No Known Allergies	☐ Penicillin	☐ Tetracycline
☐ Latex	☐ Non-Steroidal (Aleve, Ibuprofen)	☐ Sulfa

Other: _____

What is your tobacco use history?

Smoker status:	☐ Current daily smoker	☐ Current some day smoker
	☐ Never smoked	☐ Former smoker

Past Medical Eye History

☐ Blurred Vision	☐ Cataract	☐ Dry Eyes
☐ Eye Injury	☐ Eye Surgery	☐ Glaucoma
☐ Lasik	☐ Lazy Eye	☐ Macular Degeneration

Other: _____

Family History

☐ Cataracts	☐ Diabetes	☐ Glaucoma
☐ High Blood Pressure	☐ Macular Degeneration	☐ Retinal Detachment

Do you experience any of these symptoms?

☐ Allergies	☐ Arthritis	☐ Asthma Symptoms
☐ Bronchitis	☐ Burning	☐ Chronic Infection of Eye/Lids
☐ Cold Symptoms	☐ Congestion	☐ Contact Lens Discomfort
☐ Contact Lens Solution Sensitivity	☐ Dry Eyes	☐ Dry Throat/Mouth
☐ Eye Pain/Soreness	☐ Fluctuating Visual Acuity	☐ Headaches
☐ Itching	☐ Joint Pain	☐ Light Sensitivity
☐ Middle Ear Congestion	☐ Mucus Discharge	☐ Occasional Tearing
☐ Redness	☐ Sandy/Gritty Feeling	☐ Seasonal Allergies
☐ Sinus Congestion	☐ Sneezing	☐ Sties, Chalazion
☐ Tired Eyes	☐ Watery Eyes	

Any other symptoms we should know about: _____

_____

Are your eyes sensitive to?

☐ Air Conditioning	☐ Blowers	☐ Cigarette Smoke
☐ Dust	☐ Heaters	☐ Pollen
☐ Sunshine	☐ Video Display Terminals	☐ Wind

Other: _____

Patient Signature: _____