Patient Information • Medical History

Name:_____Date:_____
First Mid. Last

Address:_____City:_____State:_____Zip:_____

Birth Date:_____Social Security#_____Home Phone#_____

Work Phone#_____Cell Phone#_____Email Address:_____

Place of Employment • Occupation

_____

_____

Date of Last Eye Exam_____ Location of Last Exam_____

Billing and Insurance Information

Responsible Party:_____Relationship_____

Social Security #_____Birth Date_____

Primary Vision Insurance_____

Subscriber Name_____Place Employed_____

Birth Date_____Social Security # or ID #_____

If you do not have insurance how will you be paying for today's services?

Cash □ Check □ Credit Card □ Health Savings Account □

Medical History

Do you have any allergies to medications? Yes □ No □

If yes, please explain_____

List any medications you take (including oral contraceptives, over the counter meds and home remedies)._____

_____

_____

_____

List all major injuries, surgeries, and/or hospitalizations

_____

_____

_____

Check if you have had: Crossed Eyes ☐ • Lazy Eye ☐ • Drooping Eyelids ☐ • Glaucoma ☐ • Retinal Disease ☐ • Cataracts ☐ • Infections or injuries ☐

Are you pregnant or nursing? Yes ☐ No ☐

Do you wear glasses? Yes ☐ No ☐ If yes, how old are you current pair?____

Do you wear contacts? Yes ☐ No ☐ If yes, how old is your current pair?____ What type? Rigid ☐ Soft ☐ Other ☐

Family History

Please note any family history (parents, grandparents, siblings, children) for the following conditions:

Cataracts……..…Yes☐ No☐ Relationship_____

Crossed Eyes……..… Yes☐ No☐ Relationship_____

Glaucoma……..… Yes☐ No☐ Relationship_____

Macular Degeneration…….. Yes☐ No☐ Relationship_____

Retinal Detachment or Disease…… Yes☐ No☐ Relationship_____

Arthritis……..… Yes☐ No☐ Relationship_____

Cancer…….. Yes☐ No☐ Relationship_____

Diabetes…… Yes☐ No☐ Relationship_____

Heart Disease…….. Yes☐ No☐ Relationship_____

High Blood Pressure……..... Yes☐ No☐ Relationship_____

Social History **This information is kept confidential. However you may discuss this portion directly with the doctor if you prefer.**

Yes☐ I would prefer to discuss my "social history" information directly with the doctor. (Please check box)

Do you drive? Yes ☐ No ☐ If yes, do you have any visual difficulty when driving? Yes ☐ No ☐ If yes, please describe:_____

_____

_____

_____

_____

Do you use tobacco products? Yes ☐ No ☐ If yes, what type, amount, and for how long?_____

Do you drink alcohol? Yes ☐ No ☐ If yes, amount, and for how long?_____

Do you use illegal drugs? Yes ☐ No ☐ If yes, what type, amount, and for how long?_____

Have you ever been exposed or infected with? Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ Date of Diagnosis_____

Review of Systems

Do you currently, or have you ever, had any problem in the following areas?

Constitutional	**NO**	**YES**	**?**
Fever, Weight Loss/Gain	☐	☐	☐
Integumentary			
Skin	☐	☐	☐
Neurological			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Eyes			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision / Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy and Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing / Watering	☐	☐	☐
Glare / Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infections of Eye or Lid	☐	☐	☐
Sties	☐	☐	☐
Flashes / Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
Endocrine			
Thyroid / Other Glands	☐	☐	☐
Allergic / Immunology	☐	☐	☐

Ears, Nose, Mouth, Throat	**NO**	**YES**	**?**
Allergies, Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Vascular / Cardiovascular			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
Gastrointestinal			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Genitourinary			
Genitals / Kidneys / Bladder	☐	☐	☐
Bones / Joints / Muscles			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
Lymphatic / Hematological			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
Psychiatric	☐	☐	☐

If you have answered YES to any of the above or have conditions not listed, please explain:

_____

_____

_____

_____

_____

_____

_____ _____

Doctor’s Signature Date