

PLEASE FILL OUT COMPLETELY

MEDICAL HISTORY

Date _____/_____/_____

Last Name _____ First Name _____ M F

Address _____ Phone _____

Email: _____

City _____ State _____ Zip _____

Birthdate _____/_____/_____ Age _____ Occupation _____

Guardian (if applicable) _____ Last Eye Exam _____/_____/_____

Do you have vision insurance? No Yes If yes, insurance carrier _____

Name of Member _____ Member's Social Security # _____

Date of Birth of Member _____

Do you have health insurance? No Yes If yes, insurance carrier _____

Do you have medicare? No Yes If yes, insurance carrier _____

Primary Care Doctor _____ Address: _____

Doctor's Telephone # _____ City/Zip Code: _____

Referred By: _____ Signature: _____

Medical History

Do you have any allergies to medication? No Yes If yes, list _____

List medications you take (including oral contraceptives, aspirin, over-the-counter medications, and home remedies)

List all eye surgeries and/or injuries you have had: _____

Circle any of the following that you have had:

crossed eyes, lazy eye, drooping eyelid, glaucoma, cataracts, retinal disease, eye infections, or eye injury

Are you pregnant and/or nursing? No Yes

Do you wear glasses? No Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? No Yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? No Yes

What brand of contact lenses do you wear? _____

How often do you dispose of your contact lenses? _____ Are are you interested in contacts? No Yes

Family Medical History

Please note any history for the following conditions for you or a close family member:

Disease/Condition	Self	Relative	None	Disease/Condition	Self	Relative	None
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History – This information is kept strictly confidential. However, you may discuss this portion with the doctor if you prefer.

Yes, I prefer to discuss my Social History information directly with the doctor.

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

Do you use tobacco products? No Yes If yes, type/amount/how long _____

Do you drink alcohol? No Yes If yes, type/amount/how long _____

Do you use illegal drugs? No Yes If yes, type/amount/how long _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis None

Review of Systems

Do you currently, or have you ever had, any problems in the following areas:

Constitutional	Yes			Endocrine	Yes
Fever, Weight Loss/Gain	<input type="checkbox"/>			Thyroid/Other Glands	<input type="checkbox"/>
Integumentary				Ear, Nose, Mouth, Throat	
Skin	<input type="checkbox"/>			Allergies/Hay Fever	<input type="checkbox"/>
Neurological				Sinus Congestion	<input type="checkbox"/>
Headaches	<input type="checkbox"/>			Dry Throat/Mouth	<input type="checkbox"/>
Migraines	<input type="checkbox"/>			Respiratory	
Seizures	<input type="checkbox"/>			Asthma	<input type="checkbox"/>
Eyes				Chronic Bronchitis	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>			Emphysema	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>			Vascular/Cardiovascular	
Distorted Vision/Halos	<input type="checkbox"/>			Diabetes	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>			Heart Pain	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>			High Blood Pressure	<input type="checkbox"/>
Redness	<input type="checkbox"/>			Vascular Disease	<input type="checkbox"/>
Itching	<input type="checkbox"/>			Bones/Joints/Muscle	
Burning	<input type="checkbox"/>			Rheumatoid Arthritis	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>			Muscle Pain	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>			Joint Pain	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>			Allergic/Immunologic	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>			Psychiatric	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>				

If you answered yes to any of the above, or have a condition not listed, please explain and list medications:

Doctor's Signature _____ Date _____ / _____ / _____