Medical History

WELCOME TO OUR OFFICE
We will be happy to help you fill out this form, ask for assistance.

Mr.
Mrs.
Miss
Ms.
Dr.

Legal Last Name

First Name

M.I.

Nickname ________________________ Preference of Doctor ________________________

Today's Date: _____/_____/_____
Home Phone: ________________________
Cell Phone: ________________________
Work Phone: ________________________
Last Eye Exam: _____/_____/_____
Dr.'s Name ________________________

Address ________________________ Apt. # ________ City ____________ St ________ Zip ________

E Mail Address ________________________

Occupation (How you use your eyes) ________________________ Sex ❑ Male ❑ Female Date of Birth ________________

Drivers License # ________________ State ____________ Social Security No. ________________

OTHER FAMILY MEMBERS, STILL LIVING AT HOME:

Spouse ________________ Age ________ Name ________________ Age ________
Name ________________ Age ________ Name ________________ Age ________
Name ________________ Age ________ Name ________________ Age ________

Referred by (circle): Family Friend Doctor Radio TV Yellow Pages Newspaper Coupon Walk-in Billboard

If personally referred, whom may we thank for the referral ________________________

Method of payment, (please circle): Cash Credit Card Medicare Medicaid VSP Insurance Check *Checks returned for lack of funds will be electronically debited from your account for the check amount plus a processing fee of $30.00.*

FOR PATIENTS WITH INSURANCE: *In order to process your insurance claim, you must present your insurance card or voucher at the time of service Failure to do so may result in denial of your claim. Please understand that you are financially responsible for all charges, whether or not paid by said insurance.*

Medical History

Do you have any allergies to medications? ❑ no ❑ yes If yes, please list: ________________________

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

List all major injuries, surgeries and/or hospitalizations you have had: ________________________

Circle the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts,

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: ❑ Soft ❑ Extended Wear ❑ Rigid ❑ Other Are they comfortable? ❑ yes ❑ no

Family History

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

DISEASE / CONDITION	NO	YOURSELF	RELATIVE
Blindness	❑	❑	❑ ________
Cataract	❑	❑	❑ ________
Crossed Eyes	❑	❑	❑ ________
Glaucoma	❑	❑	❑ ________
Macular Degeneration	❑	❑	❑ ________
Retinal Detachment / Disease	❑	❑	❑ ________
Arthritis	❑	❑	❑ ________
Cancer	❑	❑	❑ ________
Diabetes	❑	❑	❑ ________
Heart Disease	❑	❑	❑ ________
High Blood Pressure	❑	❑	❑ ________
Kidney Disease	❑	❑	❑ ________
Lupus	❑	❑	❑ ________
Thyroid Disease	❑	❑	❑ ________
Other ________	❑	❑	❑ ________

✳Please turn this form over and complete side two✳

Social History

This information is kept strictly 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 my doctor. (Check box)

Do you drive? ❒ no ❒ yes if yes, do you have difficulty when driving? ❒ no ❒ yes If yes 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

Review of Systems

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

SYSTEM	NO	YES
CONSTITUTIONAL		
Fever, Weight Loss /Gain	❒	❒
INTEGUMENTARY (Skin)	❒	❒
NEUROLOGICAL		
Headaches	❒	❒
Migraines	❒	❒
Seizures	❒	❒
EYES		
Loss of Vision	❒	❒
Blurred Vision	❒	❒
Distorted Vision /Halos	❒	❒
Loss of Side Vision	❒	❒
Double Vision	❒	❒
Dryness	❒	❒
Mucous Discharge	❒	❒
Redness	❒	❒
Sandy or Gritty Feeling	❒	❒
Itching	❒	❒
Burning	❒	❒
Foreign Body Sensation	❒	❒
Excess Tearing /Watering	❒	❒
Glare /Light Sensitivity	❒	❒
Eye Pain or Soreness	❒	❒
Chronic Infection of Eye or Lid	❒	❒
Sties or Chalazion	❒	❒
Flashes /Floaters in Vision	❒	❒
Tired Eyes	❒	❒
ENDOCRINE		
Thyroid /Other Glands	❒	❒

	NO	YES
EARS, NOSE, MOUTH, THROAT		
Allergies /Hay Fever	❒	❒
Sinus Congestion	❒	❒
Runny Nose	❒	❒
Post-Nasal Drip	❒	❒
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 /Kidney /Bladder	❒	❒
BONES /JOINTS /MUSCLES		
Rheumatoid Arthritis	❒	❒
Muscle Pain	❒	❒
Joint Pain	❒	❒
LYMPHATIC /HEMATOLOGIC		
Anemia	❒	❒
Bleeding Problems	❒	❒
ALLERGIC /IMMUNOLOGIC	❒	❒
PSYCHIATRIC	❒	❒

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

Doctor's Signature

Date