PATIENT HISTORY

Last Name____________________________ First Name__________________________ Date_______________________

Address____ Birthdate_________________________

City__________________________ State_______ Zip_____________ Occupation_______________________

Home Phone______________________ Cell Phone___________________ Work Phone______________________

Emergency Contact Name__________________________________ Relationship ______________________________

Emergency Contact Phone Number_______________________ Marital Status: Single / Married / Widowed / Divorced

Email Address____

Vision Insurance carrier/member ID____

Medical Insurance carrier/member ID____

Do you have Medicare? Y N Medicare Advantage plan? Y N Last Eye Exam___________________

MEDICAL HISTORY

Name of primary care physician____

Do you have allergies to medication? No Yes If yes, please list__________________________________

____

List medications you are taking (including oral contraceptive, aspirin, over-the-counter medications)

____

____

List all major injuries, surgeries, and/or hospitalizations you have had_______________________________

____

List any of the following that you have had - crossed eyes, lazy eye, drooping eyelids, glaucoma, cataracts, retinal disease, eye infections, or eye injury ____

Are you pregnant or nursing? N/A No Yes

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

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

Type of contact lenses: Soft Rigid Other Brand, if known:__________________________________

FAMILY HISTORY

Please note any FAMILY HISTORY (parents, grandparents, siblings, aunts, uncles; living or deceased) for the following:

Disease/Condition			**Relationship**
Adopted	No	Yes	
Blindness	No	Yes	____________________
Cataracts	No	Yes	____________________
Crossed Eyes	No	Yes	____________________
Glaucoma	No	Yes	____________________
Macular Degeneration	No	Yes	____________________
Retinal Disease	No	Yes	____________________
Arthritis	No	Yes	____________________
Cancer	No	Yes	____________________
Diabetes	No	Yes	____________________
Heart Disease	No	Yes	____________________
High Blood Pressure	No	Yes	____________________
Kidney Disease	No	Yes	____________________
Lupus	No	Yes	____________________
Thyroid Disease	No	Yes	____________________

Name____

SOCIAL HISTORY

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

If yes, please describe:____

Have you ever used tobacco products: No Yes Currently using? No Yes

Do you drink alcohol? No Yes

Do you use illegal drugs? No Yes

Have you ever been exposed to or infected with: Hepatitis (A, B, or C) Gonorrhea HIV Syphillis

____

REVIEW OF SYSTEMS

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

Constitutional		
Subjective fever	N	Y
Weight loss/gain	N	Y
Integumentary		
Skin changes	N	Y
Neurological		
Headaches	N	Y
Migraines	N	Y
Seizures	N	Y
Eyes		
Loss of Vision	N	Y
Blurred Vision	N	Y
Distorted Vision/Halos	N	Y
Double Vision	N	Y
Dryness	N	Y
Mucous Discharge	N	Y
Redness	N	Y
Sandy/Gritty Feeling	N	Y
Itching	N	Y
Burning	N	Y
Excess Tearing/Watering	N	Y
Glare/Light Sensitivity	N	Y
Eye Pain/Soreness	N	Y
Chronic Infection of Eye/Lid	N	Y
Styes or Chalazion	N	Y
Flashes/Floaters in Vision	N	Y
Tired Eyes	N	Y
Endocrine		
Thyroid	N	Y
Other Glands	N	Y
Ear, Nose, Throat		
Allergies/Hay Fever	N	Y
Sinus Congestion	N	Y
Runny Nose	N	Y
Post-Nasal Drip	N	Y
Chronic Cough	N	Y
Dry Mouth/Throat	N	Y
Respiratory		
Asthma	N	Y
Chronic Bronchitis	N	Y
Emphysema	N	Y
Cardiovascular		
Diabetes	N	Y
Heart Pain	N	Y
High Blood Pressure	N	Y
Vascular Disease	N	Y
Gastrointestinal		
Chronic Diarrhea	N	Y
Chronic Constipation	N	Y
Genito-Urinary		
Genitals	N	Y
Kidney/Bladder	N	Y
Musculoskeletal		
Muscle Pain	N	Y
Joint Pain	N	Y
Rheumatoid Arthritis	N	Y
Lymphatic/Hematologic		
Anemia	N	Y
Bleeding Problems	N	Y
Psychiatric	N	Y

If you have a condition not listed, please explain/describe:______________________________________

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Patient Signature Doctor Signature