Medical History Form

PLEASE PRESENT ALL VISION AND MAJOR MEDICAL INFORMATION TO RECEPTIONIST

Date: ________________ Sex: F M

Patient's Full Legal Name: ________________________

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Date of Birth:___________________________________

Address: ______________________________________

City/state: _____________________________________

Zip code: __________________

Home Phone: _____________________

Cell Phone: _____________________

Email: ____

Emergency Contact: ________________________________

Phone Number: ____________________________________

Marital Status: □ M □ S □ D □ W

Insurance Holder's Name: ____________________________

Date of Birth: ____________ Last 4 of Social: ____________

Employer: ____

Occupation: ______________________________________

Last PCP Visit: ____________ PCP Doctor: _______________

Last eye exam: _______________

Miscellaneous

List any previous surgeries with dates:

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Are you Pregnant?	Yes	No
Are you Breastfeeding?	Yes	No

Do you wear glasses?	Yes	No
Do you wear contact lenses?	Yes	No
Are you interested in contact lenses?	Yes	No
Are you interested in laser refractive surgery?	Yes	No

Hobbies/Recreational Sports you enjoy ______________

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Review of Systems

Do you have, or have you ever had, any of the following problems or conditions?

	Yes	No
Constitutional		
Fever, Weight gain or loss	□	□
Cardiovascular		
Heart Disease	□	□
High Blood Pressure	□	□
High Cholesterol	□	□
Stoke	□	□
Vascular Disease	□	□
Ear/Nose/throat		
Allergies	□	□
Sinus Congestion	□	□
Chronic Cough	□	□
Dry Mouth/Throat	□	□
Respiratory		
Asthma	□	□
Chronic Bronchitis	□	□
Emphysema	□	□
Sleep Apnea	□	□
Genito-Urinary		
Herpes Simplex	□	□
Prostate	□	□

	Yes	No
Gastrointestinal		
Crohn's Disease	□	□
Hepatitis A	□	□
Hepatitis B	□	□
Hepatitis C	□	□
Ulcer/Reflux	□	□
Musculoskeletal		
Joint/Muscle Pain	□	□
Osteo Arthritis	□	□
Rheumatoid Arthritis	□	□
Integumentary (skin)		
Skin Cancer	□	□
Skin Disease	□	□
Herpes/Shingles	□	□
Eyes		
Dry Eye	□	□
Glaucoma	□	□
Cataracts	□	□
Macular Degeneration	□	□
Other	□	□

	Yes	No
Neurological		
Headache	□	□
Migraines	□	□
Multiple Sclerosis	□	□
Gout	□	□
Seizures	□	□
Psychiatric		
Anxiety/Depression	□	□
Endocrine		
Diabetes Type 1	□	□
Diabetes Type 2	□	□
Thyroid/Other Glands	□	□
Lymphatic-Hematologic		
Anemia	□	□
Bleeding problems	□	□
Allergic/Immunologic		
Eczema	□	□
Hives	□	□
Lupus	□	□
Organ Transplant	□	□

Please List Any Other Medical Conditions that you have: ________________________________

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Family Health History

(mark yes or no to each entry. If yes, list which family member including mother, father, brother, sister, maternal/paternal grandmother or maternal/paternal grandfather.)

Amblyopia (lazy eye)	□Yes □No	_______________	Strabismus (cross eyes)	□Yes □No	__________________
Blindness	□Yes □No	______________	Arthritis	□Yes □No	_________________
Cataract	□Yes □No	_______________	Cancer	□Yes □No	_________________
Macular Degeneration	□Yes □No	_______________	Diabetes Mellitus	□Yes □No	_________________
Glaucoma	□Yes □No	_______________	High Blood Pressure	□Yes □No	_________________
Retinal Disorder	□Yes □No	_______________	Cardiovascular Disease	□Yes □No	_________________
			Stoke	□Yes □No	_________________

Tobacco Use (mark which one applies)

□ Heavy Tobacco Smoker □ Light Tobacco Smoker □ Never a smoker □ Former Smoker

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Medications

List all CURRENT prescriptions, over-the-counter prescriptions, eye drops and dosages for each.

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____
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____
____

□ No medication
□ Medication list scanned in

Medication Allergies

List any allergies to any medicine, dyes, or latex

____
____
____
____
____
____
____

□ No medication allergies

FOR STAFF USE ONLY

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YES NO