

Medical History Form

Name: _____ Date: _____

(last, first)

Time of last eye exam ? _____

Primary care physician and clinic name: _____

How do you hear about us ? _____

Check reasons for your visit:

- blurry distance vision (e.g. road signs)
- blurry near vision (e.g. reading)
- lost or broken glasses
- lost or torn contacts
- update prescription
- routine check up
- other

Check those you currently use:

- glasses
- soft contacts
- disposable contacts
- gas permeable contacts
- no prescription

Check if you are interested in

- glasses
- soft contacts
- disposable contacts
- colored contacts
- gas permeable (hard) contacts
- refractive (LASIK) surgery
- not sure

Current medication and the reason: ___None

Medication allergy: ___ None known

Indicate any personal or family history:

- | | | | | | | |
|----------------------|--------------------------|------|--------------------------|------|--------------------------|--------|
| glaucoma | <input type="checkbox"/> | none | <input type="checkbox"/> | self | <input type="checkbox"/> | family |
| cataracts | <input type="checkbox"/> | none | <input type="checkbox"/> | self | <input type="checkbox"/> | family |
| retinal disease | <input type="checkbox"/> | none | <input type="checkbox"/> | self | <input type="checkbox"/> | family |
| macular degeneration | <input type="checkbox"/> | none | <input type="checkbox"/> | self | <input type="checkbox"/> | family |
| blindness | <input type="checkbox"/> | none | <input type="checkbox"/> | self | <input type="checkbox"/> | family |
| diabetes | <input type="checkbox"/> | none | <input type="checkbox"/> | self | <input type="checkbox"/> | family |
| high blood pressure | <input type="checkbox"/> | none | <input type="checkbox"/> | self | <input type="checkbox"/> | family |
| arthritis | <input type="checkbox"/> | none | <input type="checkbox"/> | self | <input type="checkbox"/> | family |
| heart disease | <input type="checkbox"/> | none | <input type="checkbox"/> | self | <input type="checkbox"/> | family |
| cancer | <input type="checkbox"/> | none | <input type="checkbox"/> | self | <input type="checkbox"/> | family |
| HIV / AIDS | <input type="checkbox"/> | none | <input type="checkbox"/> | self | <input type="checkbox"/> | family |
| Lupus | <input type="checkbox"/> | none | <input type="checkbox"/> | self | <input type="checkbox"/> | family |
| Thyroid Disease | <input type="checkbox"/> | none | <input type="checkbox"/> | self | <input type="checkbox"/> | family |

Mark any you have experienced:

- eye injury
- eye surgery
- severe eye disease or infection
- double vision
- dryness / burning
- sties or chalazion
- distorted vision / halo
- lazy eye
- flashing lights or spots
- sudden complete loss of vision
- other
- None of these

For woman only, Pregnant / Nursing yes no

Review of System: Please briefly indicate any condition you have regarding to the different body system that is not already listed above or below (circle sub-organ condition if applicable).

- | | | |
|--|-------|-------------------------------|
| Major hospitalization / surgery: | _____ | <input type="checkbox"/> none |
| Recent Fever / Weight Loss or Gain: | _____ | <input type="checkbox"/> none |
| Skin: | _____ | <input type="checkbox"/> none |
| Neurological (Headaches / Migraines / Seizures): | _____ | <input type="checkbox"/> none |
| Endocrine (Thyroid / Other Glands): | _____ | <input type="checkbox"/> none |
| Ears / Nose / Mouth / Throat: | _____ | <input type="checkbox"/> none |
| Respiratory (Lung problems): | _____ | <input type="checkbox"/> none |
| Vascular (Heart condition / Diabete) | _____ | <input type="checkbox"/> none |
| Gastrointestinal (Diarrhea / Constipation) | _____ | <input type="checkbox"/> none |
| Genitourinary (Genitals / Kidney / Bladder): | _____ | <input type="checkbox"/> none |
| Bone / Joints / Muscles: | _____ | <input type="checkbox"/> none |
| Lymphatic / Hematologic (Anemia / Bleeding problem): | _____ | <input type="checkbox"/> none |
| Psychiatric: | _____ | <input type="checkbox"/> none |

Social History: ___ I would prefer to discuss my Social History information directly with the doctor

- | | | | | |
|------------------------------|------------------------------------|--|---|-------------------------------|
| Do you: | <input type="checkbox"/> Smoke | <input type="checkbox"/> Drink Alcohol | <input type="checkbox"/> Use illegal drug | <input type="checkbox"/> none |
| Have you been infected with: | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Syphilis | <input type="checkbox"/> none |

I understand that the information I have provided is confidential. I give my consent for the doctor's office to use this information as needed for my treatment, for billing or obtaining payment of fee, and for the general business activities specific to this office. This information may be used in certain other specific cases as outlined in the full text of the Notice of Privacy Practice, which is posted in the office and available for review.

Patient Signature _____ Date _____