O.M._____

Initials:_____

Date:_____

PLEASE FILL OUT COMPLETELY

# MEDICAL HISTORY

E-mail_____ Preferred Language_____ Communication ❒ Email

Last Name_____ First Name_____ Pref: ❒ Postal

Address_____ Phone_____ ❒ Phone

City_____ State_____ Zip_____ Cell Number _____

Birthdate _____ ❒ Male ❒ Female Occupation _____

Guardian (if applicable)_____ Relationship_____ Last Eye Exam _____

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

Name of Member_____

Member's Social Security #_____ Member Date of Birth _____

Do you have health insurance? ❒ No ❒ Yes If yes, name of insurance _____

Name of Member_____

Member's Social Security #_____ Member Date of Birth _____

Do you have medicare? ❒ No ❒ Yes

Primary Care Doctor's Name_____

Primary Care Doctor's Address_____

Primary Care Doctor's Phone_____

Referred by: _____ Signature:_____

## Medical History

Do you have any allergies to medication? ❒ No ❒ Yes If yes, explain_____

_____

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

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

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 eyelid, glaucoma, cataracts, retinal disease, eye infections, or eye injury _____

Are you pregnant and/or nursing? ❒ No ❒ Yes If pregnant, how many weeks? _____ Due Date? _____

Do you wear glasses? ❒ No ❒ Yes If yes, how old? _____ Type: ❒ Single Vision ❒ Bifocal ❒ Progressive

Do you wear contact lenses? ❒ No ❒ Yes If yes, how old is current pair?_____ Are they comfortable? ❒ No ❒ Yes

Type of contact lenses: ❒ Soft ❒ Gas Perm ❒ Hybrid ❒ Other_____

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 History

Please note any family history for the following conditions:

| Disease/Condition | Self | Relative | None |
|---|---|---|---|
| Blindness | ❒ | ❒ | ❒ |
| Cataract | ❒ | ❒ | ❒ |
| Crossed Eyes | ❒ | ❒ | ❒ |
| Glaucoma | ❒ | ❒ | ❒ |
| Macular Degeneration | ❒ | ❒ | ❒ |
| Retinal Detachment/Disease | ❒ | ❒ | ❒ |

Other _____

_____

_____

_____

| Disease/Condition | Self | Relative | None |
|---|---|---|---|
| Diabetes | ❒ | ❒ | ❒ |
| Heart Disease | ❒ | ❒ | ❒ |
| High Blood Pressure (Hypertension) | ❒ | ❒ | ❒ |
| Cancer | ❒ | ❒ | ❒ |
| Kidney Disease | ❒ | ❒ | ❒ |
| Lupus | ❒ | ❒ | ❒ |
| Thyroid | ❒ | ❒ | ❒ |
| Arthritis | ❒ | ❒ | ❒ |

Other _____

_____

## 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

Do you have vision restriction on your driver's license? ❒ No ❒ Yes

Tobacco Use: ❒ Never Smoked ❒ Former Smoker ❒ Current Everyday Smoker ❒ Current Some Day Smoker
❒ Smoker, Current Status Unknown ❒ Current Smokeless Tobacco User

Alcohol Use: ❒ None ❒ Social Use Only ❒ 1-2 Drinks Daily ❒ Above Average ❒ Chemical Dependence

Narcotic Use: ❒ None ❒ Recreational Use ❒ Chemical Dependence

Sexually Transmitted Disease: ❒ No ❒ Yes ❒ HIV Positive ❒ Other: _____

## Review of Systems

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

| | 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 | ❒ |
| Stye or Chalazion | ❒ |
| Flashes/Floaters in Vision | ❒ |
| Tired Eyes | ❒ |
| **Endocrine** | |
| Thyroid/Other Glands | ❒ |

| | Yes |
|---|---|
| **Ear, 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** | |
| Chronic Diarrhea | ❒ |
| Chronic Constipation | ❒ |
| **Genitourinary** | |
| Genitals/Kidney/Bladder | ❒ |
| **Bones/Joints/Muscle** | |
| 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_____