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MEDICAL HISTORY

(PLEASE FILL OUT COMPLETELY)

Last Name:______________________________________ First Name:______________________________________
Address:____ Home Phone:_____________________________________
City:____________________ State:_____ Zip:______ Cell Phone:______________________________________
Birthdate:________________ Sex: Male Female Occupation:_____________________________________
Social Security #:_________________________________
Guardian (if applicable):___________________________ Relationship:____________________________________
E-mail:____
Communication Pref. (Circle One): Home Cell Text Email

Vision Insurance? Y N Vision Insurance Carrier:____
Name of Member:_________________________________ Member Date of Birth:_____________________________
Member Social Security # :__________________________ Member ID#:_____________________________________

Health Insurance? Y N Health Insurance Carrier:____
Name of Member:_________________________________ Member Date of Birth:_____________________________
Member Social Security # :__________________________ Member ID#:_____________________________________

Medical History:

Primary Care Physician:__________________________________

Do you have any allergies, including medication and environmental? Yes or No If yes, please explain________________
____

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

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____

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, retinal disease, eye infections, or eye injury____

Are you pregnant and/or nursing [ ] No [ ] Yes If pregnant, how many weeks?______________ Due Date:_____________

Tobacco Use: [ ]Never Smoked [ ]Former Smoker [ ] Current Everyday Smoker [ ]Current Some Day Smoker
[ ] Current Smokeless Tobacco User

Eye Color:_______________ Date and location of last eye exam:____

Do you wear glasses? [ ] No [ ] Yes If yes, at what age did you start wearing glasses? ____________
Glasses Type: [ ] Single vision [ ] Bifocal [ ] Progressives

Do you wear contacts? [ ] No [ ] Yes If yes, what brand do you wear? __________________________
How often do you dispose of contact lenses? ________________

Health History:

Please note any family history for the following conditions:

Disease/Condition	Self	Relative
Blindness	[ ]	[ ]
Cataract	[ ]	[ ]
Crossed Eyes	[ ]	[ ]
Glaucoma	[ ]	[ ]
Macular Degeneration	[ ]	[ ]
Retinal Detachment/Disease	[ ]	[ ]
Heart Disease	[ ]	[ ]
High Blood Pressure	[ ]	[ ]
Cancer	[ ]	[ ]

Disease/Condition	Self	Relative
Kidney Disease	[ ]	[ ]
Lupus	[ ]	[ ]
Thyroid Dysfunction	[ ]	[ ]
Arthritis	[ ]	[ ]
Diabetes Type 1	[ ]	[ ]
Diabetes Type 2	[ ]	[ ]

Other____
____
____

Review of Systems:

	YES		YES
Constitutional:		**Bones/Joints/Musculoskeletal:**	
Fever, Weight Loss/Gain	[ ]	Rheumatoid Arthritis	[ ]
		Muscle Pain	[ ]
Vascular/Cardiovascular:		Joint Pain	[ ]
High Cholesterol	[ ]		
Heart Pain	[ ]	**Integumentary:**	
High Blood Pressure	[ ]	Skin	[ ]
Vascular Disease	[ ]		
		Neurological:	
Ear, Nose, Mouth, Throat:		Headaches	[ ]
Allergies/Hayfever	[ ]	Migraines	[ ]
Sinus Congestion	[ ]	Seizures/Tremors	[ ]
Runny Nose	[ ]		
Post-Nasal Drip	[ ]	**Psychiatric:**	
Chronic Cough	[ ]	Depression	[ ]
Dry Throat/Mouth	[ ]	Dementia	[ ]
		Anxiety	[ ]
Respiratory:			
Asthma	[ ]	**Endocrine:**	
Chronic Bronchitis	[ ]	Thyroid/Other Glands	[ ]
Emphysema	[ ]	Diabetes (Type 1 or Type 2)	[ ]
Gastrointestinal:		**Lymphatic/Hematologic:**	
Chronic Diarrhea	[ ]	Anemia	[ ]
Chronic Constipation	[ ]	Bleeding Problems	[ ]
Genitourinary:		**Allergic/Immunologic:**	[ ]
Genitals/Kidney/Bladder	[ ]		

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