

Eyecare Associates

Patient Medical History

Revised 10/28/2009

Last Name: _____		First Name: _____		MI: _____	Birth Date: ____ / ____ / ____	
Name of Medical Doctor: _____			Occupation: _____		Male	Female
MEDICAL HISTORY						
Do you have any allergies to medications? No / Yes If yes explain.						
List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):						
List all major injuries, surgeries and/or hospitalizations you have had in the past 5 years:						
Circle any of the following that you have had: Crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury.						
Are you pregnant and/or nursing? No / Yes						
Do you wear glasses? No / Yes If yes, how old is your present pair of lenses?						
Do you wear contact lenses? No / Yes If yes, how old is your present pair of lenses?						
Type of contact lenses: Rigid Soft Extended wear Other Are they comfortable? No / Yes						
FAMILY HISTORY <i>Have your parents, grandparents, siblings been treated for the following conditions:</i>						
Disease/Condition	N	Y	Relationship to you:	Disease/Condition	N	Y
Arthritis				Cancer		
Diabetes				High Blood Pressure		
Glaucoma				Heart Disease		
Macular Degeneration				Kidney Disease		
Any Other						
SOCIAL HISTORY <i>This information is kept strictly confidential. However you may discuss this portion directly with the doctor if you prefer.</i>						
○ Yes, I would prefer to discuss my social history information directly with my doctor. (check circle)						
Do you drive? No / Yes If yes, do you have visual difficulty when driving? No / Yes						
If YES to visual difficulty please describe:						
Do you use tobacco products? No / Yes If yes, type / amount / how long:						
Do you drink alcohol? No / Yes If yes, type / amount / how long:						
Do you use illegal drugs? No / Yes If yes, type / amount / how long:						
Have you ever been exposed to or infected with: ○ Gonorrhea ○ Hepatitis ○ HIV ○ Syphilis ○ N/A						
REVIEW OF SYSTEMS <i>Do you currently, or have you ever had any problems in the following areas:</i>						
	N	Y	Provide explanation / medications			
Eyes (glaucoma, cataract, retinal disease, etc.)						
Skin (acne, warts, skin cancer, rosacea, etc.)						
Cardiovascular (heart disease, chest pain, irregular heart beat, etc.)						
Endocrine (diabetes, thyroid)						
Gastrointestinal (stomach ulcers, intestinal disease, etc.)						
Musculoskeletal (arthritis, muscle aches, joint pain, swollen joints)						
Neurological (stroke, numbness, weakness, headaches, etc.)						
Respiratory (asthma, emphysema, etc.)						
Ear / Nose / Mouth / Throat (sinus, ear infection, chronic cough, etc.)						
Allergic / Immunologic (hay fever, lupus, HIV, hepatitis)						
Blood / Lymph (cholesterolemia, anemia, etc.)						
Psychiatric (anxiety, depression, insomnia)						
For Office Use Only			Follow-up visits, reviewed and signed:			
Doctor's Signature: _____			Doctor's Signature: _____		Date: _____	
Date: _____			Doctor's Signature: _____		Date: _____	
			Doctor's Signature: _____		Date: _____	