PATIENT MEDICAL HISTORY FORM

Personal Information

Date _____

Mr. Mrs. Ms. Dr. Rev._____ Gender: (Please circle) M F

Street Address: _____ City_____ State_____ Zip _____

Phone Home#_____ Work # _____ Cell/Alt# _____

Email Address _____

Date of Birth _____ Social Security # _____ Occupation _____

Name of Parent/ Spouse _____ Hobbies/Sports _____

I have been provided with a copy of the HIPPA privacy policy to read. Signature _____

I authorize the following people to pick up prescriptions and records on my behalf _____

Medical and Ocular History

Do you wear contact lenses? Y/N Brand: _____ Are you interested in contact lenses? Y/N

Do you wear glasses? Y/N

When was your last eye exam? Date _____ Where was it? _____

Who was your Doctor? _____

Do you work at a computer terminal? Y/N How many hours per day? _____

Are you interested in refractive surgery? Y/N

Do you or any family member have a history of the following:

Eye Related	**No**	**Yes Self/**	**Family**	**Eyes Continued:**	**No**	**Yes Self/**	**Family**
Blindness	☐	☐	☐	Glaucoma	☐	☐	☐
Blurred vision	☐	☐	☐	Halos	☐	☐	☐
Burning/itching	☐	☐	☐	Loss of vision	☐	☐	☐
Cataracts	☐	☐	☐	Macular Degeneration	☐	☐	☐
Chronic eye Infections	☐	☐		Mucous discharge	☐	☐	☐
Crossed eyes	☐	☐		Red eyes	☐	☐	☐
Double vision	☐	☐		Retinal detachment	☐	☐	☐
Dry eyes	☐	☐		Retinal problems	☐	☐	☐
Excessive tearing	☐	☐		**Other**			
Eye allergies	☐	☐		Cancer	☐	☐	☐
Eye pain/soreness	☐	☐		Diabetes	☐	☐	☐
Eye surgery	☐	☐		Headaches	☐	☐	☐
Flashes/floaters	☐	☐		Heart Disease	☐	☐	☐
Glare/light sensitivity	☐	☐		High Blood Pressure	☐	☐	☐

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Allergies Y/N Explain:

_____

List any medications you are currently taking:_____

List your past Ocular History and General Medical History:

_____

Medical History Required by your Insurance Company

	No	Yes Self/	Family		No	Yes Self/	Family
Musculoskeletal				**Respiratory**			
Arthritis	☐	☐	☐	Chronic Bronchitis	☐	☐	☐
Joint pain	☐	☐	☐	Emphysema	☐	☐	☐
Neurological				**Hematologic/Lymphatic**			
Seizures	☐	☐	☐	Anemia	☐	☐	☐
Other	☐	☐	☐	Bleeding problems	☐	☐	☐
Genitourinary				Swelling	☐	☐	☐
Kidneys	☐	☐	☐	Cardiovascular	☐	☐	☐
Bladder	☐	☐	☐	Heart problems	☐	☐	☐
Constitutional				Vascular disease	☐	☐	☐
Fever	☐	☐	☐	Endocrine	☐	☐	☐
Weight loss	☐	☐	☐	Thyroid problems	☐	☐	☐
Weight gain	☐	☐	☐	Other glands	☐	☐	☐
Gastrointestinal				**Allergic/Immunologic**			
Ulcers	☐	☐	☐	Hay fever	☐	☐	☐
Other	☐	☐	☐	Medicine allergies	☐	☐	☐
Ears, Nose, Mouth, Throat				Systemic allergies	☐	☐	☐
Sinus problems	☐	☐	☐	Psychiatric	☐	☐	☐
Chronic cough	☐	☐	☐				
Dry mouth/throat	☐	☐	☐				
Chronic ear infections	☐	☐	☐				

Have you ever been exposed to or infected with:

Gonorrhea Y/N

Hepatitis Y/N