PATIENT MEDICAL HISTORY FORM

Male or Female *(Please circle)*

Vision Insurance _____

Medical Insurance _____

PATIENT INFORMATION

Patient Name _____ Date of Birth _____ Patient's Social Security # _____
Home Phone _____ Work Phone _____ Cell Phone _____
Email Address _____ *(only used to provide office visit summary)* Marital Status *(Please Circle)*
Primary Language _____ Ethnicity _____ Race _____ Married Single Widowed Divorced
Special Needs _____ Occupation _____ Employer _____
Preferred Method of Communication *(Please Circle)* Home Phone Work Phone Cell Phone Email Text US Mail

ACCOUNT RESPONSIBLE

Parent Name or Acct. Responsible *(if a minor)* _____ Male or Female *(Please Circle)*
Address _____ City _____ State _____ Zip Code _____
Social Security # _____ Date of Birth _____
Home Phone _____ Work Phone _____ Cell Phone _____
Email Address _____ Place of Employment _____

MEDICATION LIST *(If more space is needed, please attach a list of all medications you are currently taking, including over-the-counter.)*

Medication	Date Started	Medication	Date Started

SOCIAL HISTORY

Does your vision limit any activities of your daily living *(driving, reading, sports, work, etc.)*? YES NO
List what may apply to you: _____
Do you drink alcohol? YES NO If YES, how much? _____
Tobacco use: YES NO If YES, ❑ Cigarette ❑ Cigar ❑ Pipe ❑ Chewing Tobacco How many years? _____

MEDICAL HISTORY

Recent surgeries or hospitalizations? YES NO Who is your primary care Physician? _____
If YES, please describe: _____
Have you ever had a blood transfusion? YES NO If YES, when: _____
Pre-Peri-Post Natal problems? YES NO If YES, describe: _____

*HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING MEDICAL CONDITIONS?

ROS

Allergic/Immunologic Neg. ___
- ❑ drug allergy
- ❑ environmental allergy
- ❑ rheumatoid arthritis
- ❑ lupus
- ❑ other
- ❑ meds _____

Cardiovascular Neg. ___
- ❑ heart disease
- ❑ hypertension
- ❑ stroke
- ❑ vascular disease
- ❑ high cholesterol
- ❑ other
- ❑ meds _____

Endocrine Neg. ___
- ❑ non-insulin dependent diabetes
- ❑ insulin dependent diabetes
- ❑ thyroid dysfunction
- ❑ Hormonal dysfunction
- ❑ other
- ❑ meds _____

Hematologic/Lymphatic Neg. ___
- ❑ anemia
- ❑ leukemia
- ❑ other
- ❑ meds _____

Eyes Neg. ___
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Macular Degeneration
- ❑ surgery
- ❑ inflammatory disorders
- ❑ flashes/floaters
- ❑ other

Respiratory Neg. ___
- ❑ cigarette smoker
- ❑ asthma
- ❑ bronchitis
- ❑ emphysema
- ❑ COPD
- ❑ other
- ❑ meds _____

Constitutional Neg. ___
- ❑ developmental disability
- ❑ weight loss
- ❑ fever
- ❑ fatigue
- ❑ trauma
- ❑ other
- ❑ meds _____

Ear, Nose, Mouth, Throat Neg. ___
- ❑ inner ear
- ❑ sinus
- ❑ hearing loss
- ❑ other
- ❑ meds _____

Gastrointestinal Neg. ___
- ❑ Crohn's
- ❑ colitis
- ❑ ulcer
- ❑ digestive
- ❑ acid reflux
- ❑ other
- ❑ meds _____

Genitourinary Neg. ___
- ❑ STD - viral herpetic, chlamydia
- ❑ bladder
- ❑ prostate
- ❑ other
- ❑ meds _____

Integumentary Neg. ___
- ❑ eczema
- ❑ rosacea
- ❑ psoriasis
- ❑ skin cancer
- ❑ other
- ❑ meds _____

Musculoskeletal Neg. ___
- ❑ fibromyalgia
- ❑ muscular dystrophy
- ❑ osteoarthritis
- ❑ osteoporosis
- ❑ ankylosing spondylitis
- ❑ other
- ❑ meds _____

Neurological Neg. ___
- ❑ cerebral palsy
- ❑ multiple sclerosis
- ❑ parkinson's
- ❑ epilepsy
- ❑ other
- ❑ meds _____

Psychiatric Neg. ___
- ❑ anxiety
- ❑ depression
- ❑ panic disorder
- ❑ schizophrenia
- ❑ ADD/ADHD
- ❑ other
- ❑ meds _____

FAMILY HISTORY *(Parents, Siblings or Children)*

Medical Condition			Relationship
High Blood Pressure	Y	N	
Diabetes	Y	N	
Heart Disease	Y	N	
Cancer	Y	N	
Stroke	Y	N	
High Cholesterol	Y	N	
Kidney Disease	Y	N	

Ocular Condition			Relationship
Glaucoma	Y	N	
Cataracts	Y	N	
Macular Degeneration	Y	N	
Blindness	Y	N	
Other Conditions	Y	N	