**Eye Care Professional Associates**

**Medical History Form**

\*Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_

\*Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_\_\_

\*Home Phone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_ Employed / Retired / Student / Other

\*Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_ \*SSN# \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Gender: M or F Last Eye Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_ Single / Married / Other \*Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If minor, name of responsible party: ­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Medical Exam: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_ Are you pregnant or nursing? □ No □ Yes

List all major surgeries, injuries, and/or hospitalizations you have had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies to medications? □ No □ Yes If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications you currently take, including dosage and frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which pharmacy do you currently use? Please include name and location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle any of the following you have had, now or in the past: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, eye injury, other

If other, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear glasses? □ No □ Yes If yes, how old is your present pair of lenses? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear contacts? □ No □ Yes If yes, how old is your present pair of contacts? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of contact lenses: □ Rigid □ Soft □ Other Are they comfortable? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you sleep in your contact lenses? □ No □ Yes

Reason for today’s visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY:**

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Disease/Condition** | **NO** | **YES** | **?** | **Relationship to you** |
| Blindness | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Cataract | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Crossed Eyes | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Glaucoma | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Macular Degeneration | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Retinal Detachment/Disease | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Arthritis | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Cancer (specify) | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Diabetes (specify) | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Heart Disease | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| High Blood Pressure | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Kidney Disease | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Lupus | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Thyroid Disease (specify) | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**SOCIAL HISTORY:** *This information is strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.* □ Yes, I prefer to discuss this directly with the doctor. (Check Box)

Do you drive? □ No □ Yes If yes, do you have difficulty driving? □ No □ Yes If yes, please describe: \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smoking status: □ Never smoker □ Current smoker, type/amount/how long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Former Smoker

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you sexually active? □ No □ Yes If yes, are you currently active with: □ One partner □ Multiple partners

**REVIEW OF SYSTEMS:**

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

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **System** | | | | **No** | **Yes** | **?** | **System** | | **No** | **Yes** | **?** |
| **Eyes** | | | |  |  |  | **Gastrointestinal** | |  |  |  |
|  | | Poor vision | | □ | □ | □ |  | Upset stomach | □ | □ | □ |
|  | Eye pain | | | □ | □ | □ |  | Diarrhea | □ | □ | □ |
|  | Tearing | | | □ | □ | □ |  | Constipation | □ | □ | □ |
|  | | Redness | | □ | □ | □ | **Genitourinary** | |  |  |  |
|  | | Jaw pain | | □ | □ | □ |  | Burning on urination | □ | □ | □ |
|  | | Scalp tenderness | | □ | □ | □ |  | Urinary frequency | □ | □ | □ |
|  | Amaurosis fugax | | | □ | □ | □ |  | Incontinence | □ | □ | □ |
|  | | Loss of vision | | □ | □ | □ | **Musculoskeletal** | |  |  |  |
|  | | Blurred vision | | □ | □ | □ |  | Joint pains | □ | □ | □ |
|  | | Double vision | | □ | □ | □ |  | Stiffness | □ | □ | □ |
|  | | Dryness | | □ | □ | □ |  | Arthritis | □ | □ | □ |
|  | | Itching/Burning | | □ | □ | □ |  | Rheumatoid arthritis | □ | □ | □ |
|  | | Glare/light sensitivity | | □ | □ | □ | **Integumentary** | |  |  |  |
|  | | Flashes/Floaters | | □ | □ | □ |  | Rash | □ | □ | □ |
| **Constitutional** | | | |  |  |  |  | Changing moles | □ | □ | □ |
|  | | | Fever/Chills | □ | □ | □ | **Neurological** | |  |  |  |
|  | | Unexplained weight loss/gain | | □ | □ | □ |  | Headache/Migraine | □ | □ | □ |
| **Ear, Nose, Throat, Mouth** | | | |  |  |  |  | Seizure | □ | □ | □ |
|  | | | Stuffy nose | □ | □ | □ |  | Stroke | □ | □ | □ |
|  | | Ear ache | | □ | □ | □ |  | Paralysis | □ | □ | □ |
|  | | Cough | | □ | □ | □ | **Psychiatric** | |  |  |  |
|  | | Dry mouth | | □ | □ | □ |  | Anxiety | □ | □ | □ |
| **Cardiovascular** | | | |  |  |  |  | Depression | □ | □ | □ |
|  | | | High blood pressure | □ | □ | □ |  | Insomnia | □ | □ | □ |
|  | | Rapid heart beat | | □ | □ | □ | **Endocrine** | |  |  |  |
| **Respiratory** | | | |  |  |  |  | Diabetes | □ | □ | □ |
|  | | | Congestion | □ | □ | □ |  | Hyperthyroidism | □ | □ | □ |
|  | Wheezing | | | □ | □ | □ |  | Hypothyroidism | □ | □ | □ |
|  | | Shortness of breath | | □ | □ | □ | **Allergic/Immunologic** | |  |  |  |
|  | | Asthma | | □ | □ | □ |  | Allergies | □ | □ | □ |
| **Hematologic/Lymphatic** | | | |  |  |  |  | Hay fever | □ | □ | □ |
|  | | | Bleeding | □ | □ | □ |  | Hives | □ | □ | □ |
|  | | Anemia | | □ | □ | □ |  | |  |  |  |

If you answered YES to any of the above or have a condition not listed, please explain & list medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

O.D. Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_