EYE DOCS OPTICAL

MEDICAL HISTORY FORM

Date:_____

Name:_____ Date of Birth:_____ Age:_____

Street Address:_____

City/State/Zip:_____

Home Phone: _____ Cell Phone:_____

Marital Status: Married Single

E-mail:_____

Occupation:_____

Employer:_____

Insurance Company:_____ SS#_____

Reason for your visit:

- ☐ Routine Eye Exam
- ☐ Diabetes Eye Exam
- ☐ Computer Related Discomfort
- ☐ Red Eyes
- ☐ Double Vision
- ☐ Flashes, Floaters
- ☐ Burning/Tearing Eyes
- ☐ Contact Lens Exam
- ☐ Cataracts
- ☐ Dry Eyes
- ☐ Headaches
- ☐ Light Sensitivity
- ☐ Sudden Vision Loss
- ☐ Allergies

Are there any other general health or eye issues you would like to discuss:

_____

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MEDICAL HISTORY FORM CONTINUED

Date of your last eye exam: _____

Do you presently wear eye glasses?: _____

Do you wear contact lenses?: _____

Are you interested in a consultation/fitting for contact lenses?: _____

Name of primary care physician: _____

Do you use cigarettes/tobacco?: _____ Alcohol?: _____

Are you pregnant: _____

Patient Medical History: Check all that apply

	Self	Family		Self	Family
Allergies	☐	☐	Amblyopic(lazy eye)	☐	☐
Arthritis	☐	☐	Cataract	☐	☐
Asthma	☐	☐	Eye Injury	☐	☐
Cancer	☐	☐	Eye Surgery	☐	☐
Diabetes	☐	☐	Glaucoma	☐	☐
Hepatitis	☐	☐	Macular Degeneration	☐	☐
High Blood Pressure	☐	☐	Retinal detachment	☐	☐
HIV/AIDS	☐	☐	Strabismus(eye turn)	☐	☐
Kidney Disorder	☐	☐			
Thyroid Disorder	☐	☐			

Please list any medications you are currently taking: _____

_____

_____

Any known allergies to medications?: _____

If so please list the medications:_____

_____ _____ _____

Print Patient Name Signature of patient/guardian of minor Date