MEDICAL HISTORY FORM

Name_____
Last First MI

Nickname_____

Address_____SS#_____
City State ZIP

PO BOX #_____

Cell Phone_____ Work Phone_____ DL#_____

Home Phone_____ Email_____

Other Phone_____ **Preferred Contact: Home / Work / Cell / Txt / Email**

Birthdate_____ Circle One: Employed / Full Time Student / Part Time Student

Sex: Male / Female Occupation_____Employer_____

Marital Status: Divorced / Domestic Partner / Single / Married / Never Married / Widowed

Gaurdian_____

Primary Insurance_____ ID #_____

Secondary Insurance_____ ID#_____

Name of Primary on Insurance_____Relationship to Insured: Child / Spouse / Other

Reason for visit:_____

Do you have any of the following (circle those that apply):

Ocular History: itching, redness, burning, discharge, floaters, flashes, pain, diplopia, photophobia, glaucoma, lazy eye

Ocular Surgery: cataracts, Lasik, PRK, RK, retinal detachment

Eye Meds/Drops: _____

Last Eye Exam_____ Doctor_____

Primary Vision Correction: Glasses / CL / OTC Readers Back Up specs? Yes / No Need new Glasses? Yes / No

Does anyone in the family have the following:

Glaucoma Cataracts Macular Degeneration Retinal Detachments Lazy Eye Blindness

Race: American Indian or Alaskan Native
Asian
Black or African American
Native Hawaiian or Pacific Islander
White

Ethnicity: Hispanic or Latino
Not Hispanic or Latino

Preferred Language: English / Spanish

Do you have any problems with any of the following systems? If yes, please circle

PATIENT MEDICAL HISTORY

Diabetes Yes / No

Years Diagnosed:_____

Blood Sugar: _____ When Taken_____

HbA1C:_____ When Taken_____

Hypertension Yes / No

High Cholesterol Yes / No

Thyroid Yes / No

Cardiovascular Yes / No

Cancer Yes / No

FAMILY MEDICAL HISTORY

Diabetes Yes / No

Hypertension Yes / No

High Cholesterol Yes / No

Thyroid Yes / No

Cardiovascular Yes / No

Cancer Yes / No

Pregnant/Nursing: Yes / No Recvd Flu Immunization: Yes / No Recent Tetanus Shot: Yes / No

Primary Care Physician_____ Last Visit_____ Reason for Visit_____

Medications:_____

_____

Any allergic reaction to medications or other substances?_____

SOCIAL HISTORY

Do you smoke? Current Every Day Smoker Current Some Day Smoker Former Smoker Never Smoked

Do you drink alcohol? Yes / No How much?_____

Do you use illegal drugs? Yes / No

Do you have any sexually transmitted diseases? Yes / No

Height_____ Weight_____

ADDITIONAL TESTING (May not be covered by Insurance)

Please mark the test you would like to have performed

I prefer a dilated exam	$45
I wish to have my visual field tested	$15
I wish to have the iWellness Exam	$39

These test are strongly recommended for all patients over the age of 20. It is especially important for patients with a history of high blood pressure, diabetes, headaches/migraines, floaters/flashes of light, a high spectacle prescription, retinal problems or has a family member which suffers from glaucoma or retinal problems.