MEDICAL HISTORY

New Patient_____ Former Patient_____ Today's Date_____/_____/_____
Name (First)_____(M.I)_____(Last)_____
Address(Street)_____ City_____ State_____ Zip_____
Home Phone #_____Work Phone #_____Cell Phone #_____
School/Grade (if student) _____Employer_____
Birth Date _____/_____/_____ Age_____ Sex: M F Social Security #:_____/_____/_____
Marital Status_____Spouse or Parent's Name_____
Email Address _____-

Medical History

Date of Last Medical Exam_____/_____/_____ Name of Medical Doctor:_____
Date of Last Eye Exam____/_____/_____ Who last examined your eyes?_____
Have your eyes ever been dilated?_____ Any adverse reaction?_____
Have you ever had any eye injury?_____ Eye Surgery?_____ Had to take eye meds? _____
If so, please explain_____
Are you allergic to any medications?_____If yes, please explain_____
List all major injuries, surgeries and/or hospitalization you have had_____
_____
Do you wear glasses? ____No ____Yes If yes, how old is your present pair of glasses_____
Do you want a contact lens exam today?___No___Yes
Have you ever worn contact lenses? ____No ____ Yes Rigid___ Soft___ Extended___ Toric___ Disposable___
Are you interested in discussing LASIK type refractive surgery today? _____ No _____ Yes
Are you currently pregnant? _____No _____Yes If so, how far along?_____

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

System	CHECK IF YES	System	CHECK IF YES
INTEGUMENTARY (Skin)	___	**EAR NOSE THROAT**	
NEUROLOGICAL		Allergies/Hay Fever	___
Headaches	___	Sinus Congestion	___
Migraines	___	Post Nasal Drip	___
Seizures	___	Chronic Cough	___
EYES		Dry Throat/Mouth	___
Cataracts	___	**RESPIRATORY**	
Loss of Vision	___	Asthma	___
Blurred Vision	___	Chronic Bronchitis	___
Crossed Eyes	___	Emphysema	___
Glaucoma	___		
Loss of Side Vision	___	**VASCULAR/CARDIOVASCULAR**	
Double Vision	___	Diabetes	___
Dryness	___	Heart Pain	___
Mucous Discharge	___	High Blood Pressure	___
Redness	___	Vascular Disease	___
Sandy or Gritty Feeling	___	**GASTROINTESTINAL**	
Itching	___	Diarrhea	___
Burning	___	Constipation	___
Foreign Body Sensation	___	**GENITOURINARY**	
Excess Tearing/Watering	___	Genitals/Kidney/Bladder	___
Glare/Light Sensitivity	___	**BONE/JOINTS/MUSCLES**	
Eye Pain or Soreness	___	Rheumatoid Arthritis	___
Infection of Eye or Lid	___	Muscle Pain	___
Sties/Chalazion	___	Joint Pain	___
Drooping Lid	___		
Flashes/Floaters in Vision	___	**LYMPHATIC/HEMATOLOGIC**	
Tired Eyes	___	Anemia	___
ENDOCRINE		**ALLERGIC/IMMUNOLOGIC**	___
Thyroid/Other Glands	___	**PSYCHIATRIC**	___

If Diabetic please fill in
Last Blood Sugar_____
Date/Time_____
Last A1C_____
Date/Time_____
Last Doctor Visit_____
Next Doctor Visit _____

PLEASE TURN FORM OVER AND COMPLETE SIDE TWO

Please list all medications you are currently taking_____
_____
_____
_____
__

SOCIAL HISTORY *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.* ____Yes I would prefer to discuss my Social History information directly with my doctor. (Check Space)

Do you use tobacco products? No___ Yes___ If yes, type/amount/how long:_____
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:_____
Have you ever been exposed to or infected with ___Gonorrhea ___Hepatitis ___HIV ___Syphilis

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

DISEASE/CONDITION	CHECK IF YES	RELATIONSHIP TO YOU
Blindness	___	_____
Cataract	___	_____
Crossed Eyes	___	_____
Glaucoma	___	_____
Macular Degeneration	___	_____
Retinal Detachment	___	_____
Retinal Disease	___	_____
Arthritis	___	_____
Cancer	___	_____
Diabetes	___	_____
Heart Disease	___	_____
High Blood Pressure	___	_____
Kidney Disease	___	_____
Lupus	___	_____
Thyroid Disease	___	_____
Other_____	___	_____

Who may we thank for referring you?_____

CONSENT: I give Precision Optical Eyecare Clinic, PC all authority necessary to perform diagnostic and therapeutic procedures for my best ocular health. This includes dilation, which may produce side effects and allergic reactions. Please sign below. If you are under 18 a parent or guardian must sign.

_____ _____
Patient's Signature **Date**