

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Today's date: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

Phone Number: \_\_\_\_\_ Work Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_

E-Mail address: \_\_\_\_\_ Referred by: \_\_\_\_\_

Previous Eye Doctor: \_\_\_\_\_ Last Eye Exam: \_\_\_\_\_

Current Medical Doctor: \_\_\_\_\_ Last Medical Exam: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

**Medical History**

Would you like to access your medical file by computer?  Yes  No

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

List any medications you take (including oral contraceptives, aspirin, over-the-counter medications and home remedies):  
\_\_\_\_\_  
\_\_\_\_\_

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

Check any of the following that you have had:  Reading Difficulty  Crossed Eyes  Lazy Eye  Glaucoma  
 Retinal Disease  Cataracts  Eye Injury  Macular Degeneration

Are you pregnant and/or nursing?  Yes  No  
Do you wear glasses?  Yes  No If yes, how old is your present pair of glasses? \_\_\_\_\_  
Are you interested in purchasing glasses today? \_\_\_\_\_

Do you wear contact lenses?  Yes  No If no, would you like to try contact lenses? \_\_\_\_\_  
Type of contact lenses:  Rigid  Soft  Extended wear  Other Are they comfortable?  Yes  No

Have you had refractive or any eye surgery  Yes  No If yes, what kind \_\_\_\_\_  
At work: Do you perform fine or close-up work?  Yes  No  
Do you use a computer?  Yes  No If yes, how many hours? \_\_\_\_\_  
Are you outdoors all or part of the time?  Yes  No  
Is safety protection a concern at work?  Yes  No  
Do you have trouble reading signs when driving at night?  Yes  No  
Are you bothered by the glare from: Overhead lighting  Yes  No  
A computer screen  Yes  No  
On coming headlight at night  Yes  No  
Are you sensitive to bright sunlight?  Yes  No Are you interested in purchasing sunglasses? \_\_\_\_  
What hobbies or recreational sports do you enjoy? \_\_\_\_\_

**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 box)  
Do you drive?  Yes  No If yes, do you have visual difficulty when driving?  Yes  No If yes, please describe: \_\_\_\_\_

Do you use tobacco products?  Yes  No If yes, type/amount/how long: \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, type/amount/how long: \_\_\_\_\_

Do you use recreational drugs?  Yes  No If yes, type/amount/how long: \_\_\_\_\_

Have you ever been exposed to or infected with:  Gonorrhea  Hepatitis  HIV  Syphilis  No, I have not.

**\*Please turn this form over and complete Side 2\***

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

<u>System</u>	<u>Yes</u>	<u>No</u>	<u>Family</u>	<u>Not Sure</u>	<u>System</u>	<u>Yes</u>	<u>No</u>	<u>Family</u>	<u>Not Sure</u>
<b>Cancer</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Ears, Nose, Mouth, Throat</b>				
<b>Constitutional</b>					Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Skin (Integumentary)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neurological</b>					Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Respiratory</b>				
<b>Eyes</b>					Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Vascular/Cardiovascular</b>				
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brain Injury/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Gastrointestinal</b>				
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Genitourinary</b>				
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Bones/Joints/Muscles</b>				
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye/Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sty or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Lymphatic/Hematologic</b>				
<b>Endocrine</b>					Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Psychiatric</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Allergic/Immunologic</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Assignment & Release**

I acknowledge that I received a copy of May Vision Center’s Notice of Privacy Practices. I authorize the release of any medial information necessary to process all claims. I also authorize the release of payment of medical benefits to my physician and understand I am responsible for non-covered services.

Signed \_\_\_\_\_ Date \_\_\_\_\_

*“Thank you for completing this history form. The doctor and technicians will review your entries and ask you further questions where necessary. The doctor will then customize an examination just for you! The examination will enable us to meet your specific needs. Thank you again for choosing our office. We look forward to improving the quality of your life!”*

I have reviewed this history with the patient: \_\_\_\_\_

*Doctor’s Signature / Date*